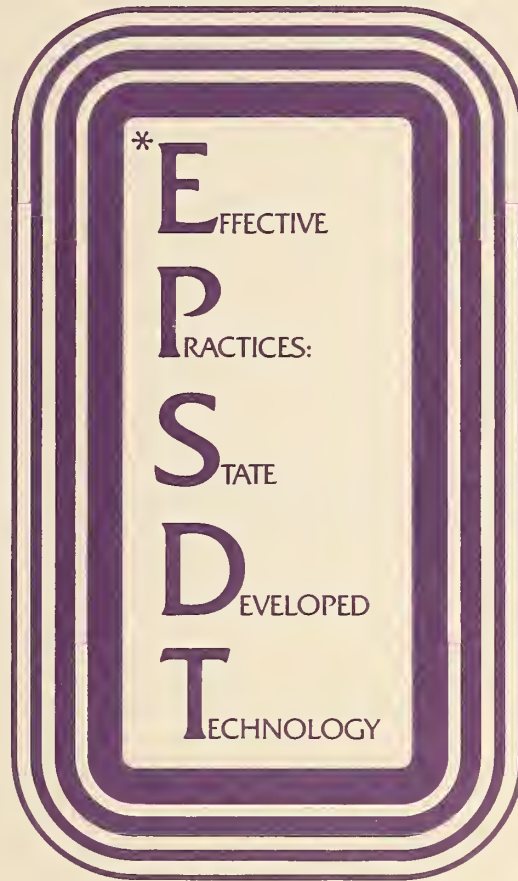


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\*Early and Periodic Screening, Diagnosis and Treatment

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EFFECTIVE PRACTICES:  
STATE DEVELOPED TECHNOLOGY

CHILD HEALTH STAFF  
OFFICE OF STANDARDS AND PERFORMANCE EVALUATION  
BUREAU OF PROGRAM OPERATIONS





## **PREFACE**



## PREFACE

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program demonstrates a unique approach within Medicaid. Enacted by Congress in 1967, EPSDT emphasizes prevention and a systematic approach to health services delivery. A proactive State management style is mandated: to enroll Medicaid recipients under age 21 in ongoing preventive and primary health programs and to assure that they receive needed health care services.

To seek out eligible children, inform them and their families about the benefits of prevention and the services available, assess their health care needs, and ensure that their needs are met through further diagnosis and treatment forms a complex set of functions. Further, in order to enable meeting the early and preventive requirements, States must provide scheduling and transportation support, when needed. In a real sense, program managers plow new ground in carrying out these new program mandates.

Federal responsibility for EPSDT program administration is vested in the Health Care Financing Administration (HCFA) of the Department of Health and Human Services (HHS). A key Federal responsibility is to assist States in meeting such program management challenges. As part of that assistance function, HCFA contracted with Birch & Davis Associates, Inc., in September 1980 to identify administrative and service delivery practices which have fostered and improved program implementation and promoted the intent of EPSDT.

The contract project was designed to cast innovative and creative concepts against operational realities. Given the unique quality of each State environment, its focus was on the breadth of effective practices in major EPSDT functional areas rather than on specifics often seen in an operational implementation manual. As a final product, this document describes certain concepts and practices which were identified through: (1) a review of EPSDT and other child health program literature, (2) a telephone survey of EPSDT coordinators in HHS Regional Offices, (3) site visits to selected States, and (4) workshops and discussions at the 1981 National EPSDT Conference.

Many State EPSDT programs are experiencing a period of change and increasing budgetary constraints. It is hoped that this document will stimulate thought, facilitate implementation of effective, appropriate practices from other jurisdictions, and continue and extend the dialogue among EPSDT practitioners at all levels of program operation, thus aiding technology transfer and intergovernmental cooperation.



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CHAPTER ONE  
PROGRAM OVERVIEW AND  
STUDY METHODOLOGY



## I. PROGRAM OVERVIEW AND STUDY METHODOLOGY

This chapter provides an overview of EPSDT's requirements and characteristics and describes the study methodology as a framework against which to view the EPSDT practices identified in Chapters II and III.

### 1. EPSDT IS BOTH PROGRAMMATICALLY COMPREHENSIVE AND ADMINISTRATIVELY DEMANDING

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (Part of Title XIX of the Social Security Act) is a preventive health care program designed to serve the nation's low income children. Although EPSDT has enjoyed increasingly enthusiastic support in the 14 years since its enactment, the program still struggles to cope with stubborn administrative problems that inhibit optimal operations.

EPSDT is an ambitious program, both in its programmatic scope and administrative structures. As a Federal-State initiative, EPSDT programs vary among States, but all programs must include health care promotion, comprehensive screening examinations followed by necessary diagnosis and treatment, and case management to assure that the appropriate services are received.

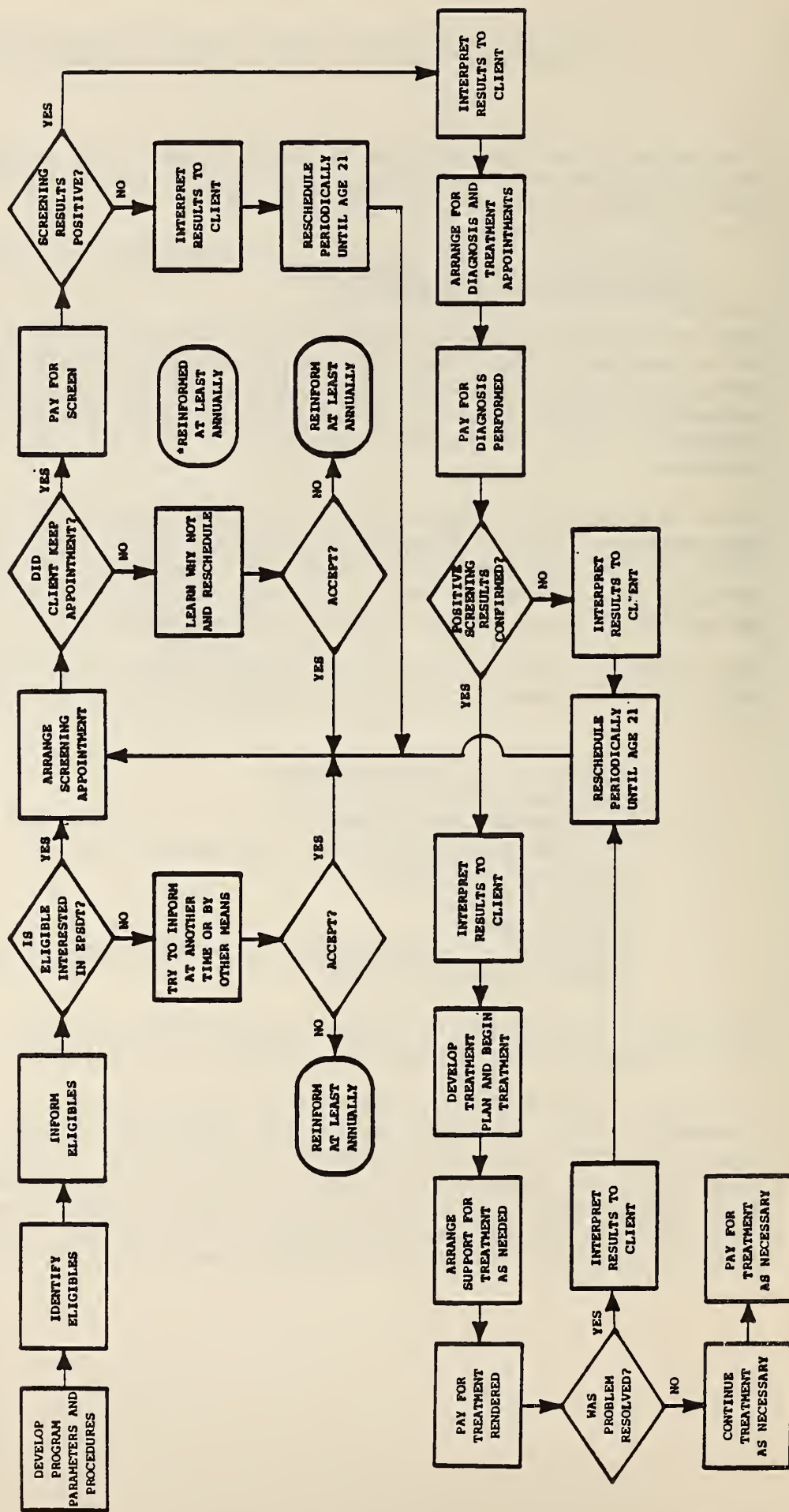
The screening examination must be performed at regular intervals (determined by the State through consultation with the medical community) and should include at least:

- Health and development history
- Unclothed physical examination
- Developmental assessment
- Immunizations appropriate for age and health history
- Nutritional assessment
- Vision testing
- Hearing testing
- Laboratory procedures appropriate for age and population
- Dental services for children

Following the examination, all children in whom medical conditions are identified must be referred for further diagnosis and appropriate treatment.

To administer EPSDT, States usually rely on case management and client tracking procedures. These procedures assure that eligible children are identified and screened (or rescreened) and that treatment is provided. Further, most States assist clients to schedule appointments and receive transportation, if needed. States have considerable latitude in carrying out the program. Even so, EPSDT in most States involves recurring events similar to those shown in Exhibit I-1. Some reasons for the variety among State EPSDT programs are discussed below.

## THE EPSDT PROCESS





## **2. EPSDT IS IMPLEMENTED IN DIVERSE STATE AND COUNTY ENVIRONMENTS**

As the foregoing section suggests, considerable variance exists among EPSDT programs; in fact, no two States have identical programs because each State's environment—administrative, political, geographic, demographic—is different. Appendix C presents some characteristics of State EPSDT environments, which are described further below.

The philosophy of the agency charged with administering EPSDT—welfare, health, umbrella—influences greatly the priority the program receives in relation to other initiatives. Similarly, the type of EPSDT administration in a State (i.e. State administered or State supervised/county administered) affects the consistency of services provided statewide; State supervised/county administered programs may have nearly as many distinct approaches to EPSDT as they have distinct counties.

The volume of EPSDT clients and their geographic distribution also influence program design and operations. Obviously, a State with over a million eligible children must operate differently from one serving 50,000 clients; State physical geographies and population densities also affect program designs.

The nature of staffing at the administering agency and the existing provider network impact EPSDT operations. In the case of the provider community, not only the number and types of providers, but their individual and collective attitude toward EPSDT can be vital to the program's success and will substantially shape its design. As a result, some EPSDT programs rely primarily on the private provider network for service delivery. Other programs are built around the network of public providers, while some use both public and private providers.

## **3. SINCE THE PROGRAM'S INCEPTION, SIGNIFICANT STRIDES HAVE BEEN TAKEN TO IMPROVE EPSDT ADMINISTRATION**

EPSDT practitioners have worked steadily to improve their programs through creative and innovative practices. Research and development characterized the early program years and kindled an experimental, creative spirit among program personnel. Four initial demonstrations identified essential program components and described local administration in environments such as an inner city day care program and a southwestern barrio. Later projects focussed on:

- Assessing the cost benefit of alternate case finding and monitoring techniques
- Attracting and maintaining adolescent participation in EPSDT
- Using different modalities to conduct developmental assessment
- Developing the school as an EPSDT provider
- Enhancing interagency collaboration to make use of community resources

States have continued to experiment with innovative practices, revising and improving their EPSDT programs. Noteworthy progress is being made in four major areas.

First, many States are improving EPSDT outreach through interagency linkages and media campaigns. Media campaigns are being implemented to extend the reach of overworked staff and enhance program appeal. An example is an EPSDT promotional program called "Check It Out With A Checkup," originally developed and field tested in DHHS Region X. This multimedia effort features television spots, buttons, posters, tee-shirt transfers, messages on grocery bags and milk cartons, and even a dance troupe that performs and distributes program literature at shopping areas and local beaches. In another State, EPSDT workers dress as clowns and, roving the service area, put on shows and distribute explanatory materials. A third State operates an EPSDT-Hotline in a major metropolitan area and publicizes the program through radio and newspaper advertisements.

Second, comprehensive health care providers are increasingly participating in the program. In the past, comprehensive providers, so important to continuity of care, have been reluctant to serve EPSDT children, fearing low reimbursement rates, broken appointments, and excessive paperwork. To combat their reluctance, one State launched an aggressive provider recruitment campaign and meets regularly with physicians to discuss problems and ideas for program improvement. As a result of efforts like these, health maintenance organizations (HMOs), fee-for-service medical groups, and other comprehensive care providers are becoming more enthusiastic about EPSDT.

Third, EPSDT functions are increasingly being performed under contract by non-profit organizations and allied agencies. Few States now lack Title V-XIX agreements. One midwestern State has established screening centers in Job Corps sites in a joint health/labor effort to reach EPSDT eligible adolescents. In another State, four counties have contracted with a non-profit agency to administer EPSDT and it appears that surrounding counties may join the consortium.

Last, States are coupling efforts to improve identification techniques with improved case tracking and provider billing techniques. As Appendix C shows, 25 States now have at least partially automated case tracking systems. A few have automated this function entirely, and automation is certain to increase. Another State developed a multipart case tracking form to incorporate identifying information, screening results, the treatment plan, treatment rendered, and billing information. The form was developed with grant funds and now is being revised to become part of the Medicaid Management Information System (MMIS).

In short, States continue work to realize EPSDT's potential and promise—to make their programs more responsive to client needs, overcome administrative barriers, and make the most of limited dollars. This study sheds light on effective practices reported by State and Federal program staff. The next section describes the methodology employed to identify these practices.



#### 4. THIS STUDY IDENTIFIED CURRENTLY EMPLOYED AND CONTEMPLATED EFFECTIVE EPSDT PRACTICES

The study reflects a positive view of EPSDT in that it focusses on efforts to improve program operations, identify program strengths, and share good news about EPSDT. The study purpose was two fold:

- Identify and describe practices that foster program implementation and promote the detection and treatment of debilitating conditions in children
- Encourage dialogue between local, State and Federal EPSDT practitioners

The study team identified effective practices through various mechanisms (described below) and then conducted workshops at the National EPSDT Conference during March 1981, in Denver, Colorado. An advisory panel of Federal, State, county, and private sector EPSDT practitioners reviewed and commented on all study products to be sure that they recognized real-world problems and procedures. The following text enumerates study activities.

##### (1) Several Methods Were Employed To Identify And Assess Effective Practices

In an effort to combine innovative and creative concepts and practices with operational realities, several methods and sources were used to identify and assess effective practices:

- A Literature Search Was Conducted—Generally an important first step in any study, a literature search was initiated to discover the extent to which EPSDT practices are documented. Among the sources consulted were HCFA publications, the National Technical Information Service, and the larger body of child health literature. The literature has not kept pace with EPSDT administrative and service delivery technology, however, and it was clear that practices that were documented might have evolved in light of regulatory changes.
- A Telephone Survey Of Federal Regional Office EPSDT Staff Was Added To The Study Design—To obtain more current data on State and local EPSDT practices than that available in the literature and to assist in selecting States to which visits might be productive, a telephone survey of each HCFA Regional Office was conducted. Either the EPSDT Coordinator or another knowledgeable staff member was contacted in each Region and asked to describe (State by State) outreach/informing activities, case management/client tracking systems, categories of providers used, major implementation problems, and significant program strengths.

Within this framework, regional officials were asked to identify State EPSDT programs considered especially effective. Having done so, they then were asked to assess the transferability of these practices to other States or localities. Particularly promising practices were earmarked for consideration as site visit locations.

- Site Visits Were Conducted To Selected States—South Carolina, Idaho, and Missouri were selected for site visits to discuss practices within the State and to gain an understanding of current needs and problems affecting program implementation. A fourth site visit was conducted to the HCFA Region X Office in Seattle to discuss the health care promotion and outreach activities tested in States in that region. A report on each site visit and the special features of each State's EPSDT program can be found in Appendix A.
- A Preliminary Report Was Prepared Following The Site Visits—The preliminary report identified administrative and service delivery practices either in use or believed to have significant potential for success in States with differing geographic, demographic, political, and other characteristics. The preliminary report also included the initial design of workshops to be conducted at the National EPSDT Conference. Following review by HCFA's Child Health Staff and the Advisory Panel of the identified practices and draft workshop format, activities commenced to refine and finalize the workshop design.

(2) Workshops At The National EPSDT Conference Were The Primary Vehicle For Identifying Effective Practices

As the workshop design neared completion, review and comments again were solicited from HCFA's Child Health Staff and the Advisory Panel. Workshops were designed to:

- Tap the participants' reservoir of practical, "hands-on" experience
- Serve as a learning experience for participants through information exchanges

These twin goals were given virtually equal weight in designing the workshops, for in prior work with EPSDT practitioners and in discussions with advisory panel and State personnel, the need for communication was a major, recurring theme. It was discovered that State EPSDT personnel communicate little with their counterparts in other States and that most are unaware of available publications, media materials and innovations with which others are experimenting. Repeatedly, State personnel indicated an interest in implementing creative, practical techniques, yet none could afford to "reinvent the wheel." Considering also recent decreases in Federal technical assistance dollars, HCFA officials sought a means of initiating dialogue both among States and between States and the Federal government.



As discussed earlier, the EPSDT process is in no two States identical, yet every State performs core EPSDT-related activities. To provide a framework for workshop discussions, therefore, EPSDT core activities were clustered into four functional areas:

- Program Design—Through these functions, the State defines and redefines its program and marshalls resources to operate it. Activities include: developing the fee and periodicity schedules, designing developmental assessment protocols, enlisting providers and maintaining their participation, defining the scope of discretionary services, and developing operating and monitoring mechanisms.
- Outreach and Informing—Although States have considerable latitude in selecting specific outreach and informing techniques, almost all promote EPSDT and distribute explanatory materials, conduct case finding, identify eligible children, inform identified individuals (or their parents) of available services through written and face-to-face contacts, periodically reinform eligible but not participating clients, and apprise participants of the need for and schedule of periodic exams.
- Case Management and Tracking—This program area constitutes the major unique quality of EPSDT within Medicaid. Unlike the balance of Medicaid activities, which is solely a vendor payment program, EPSDT conducts client tracking to ensure the continuity of care. Functions include creating a control file for each eligible child; arranging support services, exams, diagnosis and required treatment; maintaining tracking and documentation systems; ensuring client awareness of service availability and periodicity; and reporting program activities.
- Service Delivery (Screening, Diagnosis, and Treatment)—This involves arranging for or actually delivering required and discretionary services, arranging for support services as needed, and paying for services rendered.

Workshops were arranged along these four functional topics and according to State characteristics that influence program operations. For example, to discuss program design, participants were divided into four groups based on type of program administration and size of EPSDT population.

In addition to State EPSDT practitioners, Federal and private sector EPSDT personnel also attended the workshops; they were asked to take a largely non-participatory role, however, since workshops' main goal was to foster State to State dialogue and to identify State practices. Prior to the workshops, participants were asked to complete a protocol describing State EPSDT practices. In this way, the potential for dialogue was enhanced and the body of knowledge drawn from the conference expanded and documented.

All workshops were staffed both by a group leader and a facilitator/recorder. Group leaders, each a State EPSDT Coordinator, led the discussion, ensuring that it did not stray from the intended topics and that everyone wishing to contribute was recognized. The facilitator/recorder, a representative of Birch & Davis Associates, Inc., assisted the group leader in observing time frames, providing clarification, stimulating discussion and recording identified practices on flip charts.

Each workshop was divided into three segments. Participants first were asked to "brainstorm"—in a restricted time frame, to develop as many ideas as possible on effective practices (either implemented or contemplated) without any assessment of each idea's relative merits. Second, participants reviewed these ideas to identify duplications and ranked each idea to indicate how crucial it was to program effectiveness. Finally, workshop participants listed specific benefits, operational requirements, and barriers to implementation for each practice.

To further guide each workshop, participants were provided a three part packet of materials. The first section, a sample of which is shown as Exhibit I-2 described the workshop process outlined above and was reviewed by the group leader at the outset of each workshop. Participants were especially encouraged to avoid unnecessary detail and unproductive negativism and, instead, to share positive experiences and effective techniques. The second section of the packet contained forms on which participants could record each identified practice, its rank, advantages, barriers, and operational requirements. One such form is shown on Exhibit I-3. The third section of each workshop packet listed effective practices identified through preliminary study activities; these were to be used only as necessary to stimulate discussion.

In some cases, groups altered the workshop process (e.g., lengthened the brainstorming session, eliminated the ranking process). To the extent alterations did not compromise workshop goals, flexibility was encouraged. Following the workshops a brief summary of results was reported to the full conference by Birch & Davis Associates, Inc. to inform participants of activities in other groups and to provide closure.

## **5. THIS REPORT SUMMARIZES EFFECTIVE PRACTICES IDENTIFIED THROUGH ALL STUDY ACTIVITIES**

The remaining two chapters of this report describe the practices and related issues identified from all activities conducted in this project. Chapter II succinctly describes the breadth of practices identified in the four EPSDT functional areas; Chapter III describes more fully the benefits, barriers to implementation, training requirements, current implementation, and other salient information about five practices.

In both Chapters II and III, an original study premise is corroborated repeatedly, i.e., effectiveness of a practice design depends on the State environment—what proves successful in one State may not be appropriate for another State. Key factors relating to the appropriateness of a practice design include: (1) the type of agency responsible for administering EPSDT; (2) type of administration; (3) size



INTRODUCTION TO THE CASE  
MANAGEMENT/MIS WORKSHOPS

- The group leaders should promptly call the participants to order at 8:30 a.m.
- The group leader should ask each participant to introduce her/himself and to indicate the State or organization she/he represents.
- The group leader should ask each participant to sign the attached sheet (the facilitator from Birch & Davis Associates, Inc. should collect this sheet).
- The group leader should then begin the workshop by following the outline as indicated in the following pages.

FOCUS OF THE CASE MANAGEMENT/MIS WORKSHOP GROUPS

- The participants should focus on identifying effective practices for case management/MIS functions.
- The practices identified should reflect what effectively works or may work in your State.
- Remember, the workgroups have been organized so that States with similar characteristics that are relevant to this area are in the same group.
- Therefore, it can be anticipated that each group will not identify the exact same practices.
- Effective practices should be identified for the following case management/MIS EPSDT activities:
  - Create client control file for each eligible child
  - Arrange for screening exam
  - Arrange for support services for screening exam
  - Follow-up on screening exam
  - Arrange for further diagnosis and treatment
  - Arrange for support services for diagnosis and treatment

- Follow-up on diagnosis and treatment
  - Reinform eligible non-participating families once a year in writing
  - Notify eligible children of periodic exam in writing and reinstitute cycle
  - Maintain client tracking and documentation system
  - Reimburse for services
  - Report activities to lead agency and on the QCHSR
- Practices which involve interagency linkages and collaborative efforts with associations, professional groups, and delivery/local level units responsible for operating EPSDT should be stressed.
  - Although there is only an hour and forty-five minutes for this workshop, an exchange of ideas and pertinent discussion are necessary to obtain the full benefits of this exercise.

#### PROCESS FOR IDENTIFYING AND ASSESSING CASE MANAGEMENT/MIS EFFECTIVE PRACTICES

- The first step in this group workshop is to identify the effective practices.
  - The group leader should ask participants to identify effective practices.
  - This portion of the workshop should be like a brainstorming session where there is a free flow of ideas without any attempt to assess or analyze each practice.
  - The effective practices suggested should each be noted separately in Part I of the forms included in Section II.
    - The Birch & Davis Associates, Inc. facilitator will maintain the master copy.
    - Each participant should also complete the form for his/her own record of the proceedings.

- Section III contains effective practices identified by Birch & Davis Associates, Inc. that may be used to stimulate discussion or as an example for this exercise.
- This part of the workshop should last approximately 30 minutes.
- The next step in the workshop is to rank order the effective practices identified.
  - The effective practices should be quickly reviewed to assure that there is no duplication and to combine practices which are similar.
  - Classify each effective practice into one of three of the following categories:
    - Highest priority (will have the greatest impact and is most critical)
    - Medium priority (will have a substantial impact and is essential)
    - Lower priority (will have a positive impact and is a key factor)
  - These designations should be noted on Part II of the forms included in Section II for each effective practice identified.
  - This part of the workshop should last approximately 15 minutes.
- The last major exercise in the workshop is to assess each effective practice.
  - Briefly discuss each effective practice individually, beginning with those in the highest priority group.
  - First, identify in succinct terms the major advantages of the practice (e.g., reduces the paperwork burden, increase continuity of care, etc.).
  - Second, identify in succinct terms the major disadvantages of the practice or barriers to implementation (e.g., requires a substantial initial investment of resources; restricts client's freedom of choice, etc.).



- Third, identify the major operational requirements associated with the practice . . . operational requirements may reflect:
  - Unique staffing pattern requirements
  - Unique administrative or clinical procedures
  - That the practice is only appropriate for a social services SSA or for a State supervised/county administered program
- The advantages, disadvantages, and operational requirements for the effective practice should be noted on Part III of the forms included in Section II.
- Assess each effective practice individually in the same manner as described above.
- Again, Section III contains an assessment of the effective practices identified by Birch & Davis Associates, Inc. that may be used to stimulate discussion or as an example for this exercise.
- This part of the workshop should take approximately 45 minutes to complete.
- The group leader will only present to the entire assembled conference on Thursday afternoon those practices in the highest priority category (each group leader's presentation should be no longer than seven minutes).

\_\_\_\_\_  
(Workshop Area)

\_\_\_\_\_  
(Workshop Group)

\_\_\_\_\_  
(Group Leader)

PART I . . . EFFECTIVE PRACTICE:

PART II . . . RANKING: ☐ Highest Priority ☐ Medium Priority ☐ Lower Priority

P  
A  
R  
T  
  
III

ADVANTAGES:

DISADVANTAGES:

OPERATIONAL

REQUIREMENTS:

and distribution of the eligible population; (4) geographic size and topographic nature of the State; (5) existing provider network (philosophy, mix, distribution, level of participation); (6) staffing patterns of the Single State Agency, and (7) type of information system.



## CHAPTER TWO

### EFFECTIVE PRACTICES IN PROGRAM DESIGN; OUTREACH AND INFORMING; CASE MANAGEMENT; AND SCREENING, DIAGNOSIS, AND TREATMENT

and distribution of the eligible population; (4) geographic size and topographic nature of the State; (5) existing provider network (philosophy, mix, distribution, level of participation); (6) staffing patterns of the Single State Agency, and (7) type of information system.

## CHAPTER TWO

### EFFECTIVE PRACTICES IN PROGRAM DESIGN; OUTREACH AND INFORMING; CASE MANAGEMENT; AND SCREENING, DIAGNOSIS, AND TREATMENT



**SECTION A**

**EFFECTIVE PRACTICES IN PROGRAM DESIGN**



## SECTION A

### EFFECTIVE PRACTICES IN PROGRAM DESIGN

Program Design encompasses establishing or redefining policy and developing or modifying operational components required to administer EPSDT. For example, program design activities may include: (1) defining discretionary services and related procedures, (2) developing periodicity or fee schedules and screening or developmental assessment protocols, (3) developing the provider network, (4) involving allied agencies and community representatives in planning, and (5) developing and implementing mechanisms to standardize and monitor operations at the delivery level.

In addressing these activities, EPSDT program managers are concerned with three major program design goals:

- Enlist providers and maintain their participation
- Encourage community involvement in EPSDT
- Design administrative components that foster smooth operations

This section identifies effective practices that help achieve each goal.

#### GOAL 1: ENLIST PROVIDERS AND MAINTAIN THEIR PARTICIPATION

A major challenge facing EPSDT administrators is designing effective strategies for attracting providers and maintaining their interest in the program. Regardless of how sophisticated or comprehensive its other program components, an EPSDT program cannot survive without a sufficient cadre of primary and speciality care health professionals. A myriad of factors determine how difficult or simple it is to engender participation: (1) number and geographic distribution of providers, (2) provider mix, (3) provider attitudes and philosophy regarding preventive health care and EPSDT, (4) reimbursement rates, billing procedures, and timeliness of payments, and (5) administrative requirements. Because these factors and the administering agency's resources vary among jurisdictions, the strategies selected to enlist providers and maintain their participation should be tailored to the operational environment.

Experience suggests that both initial recruitment and efforts to maintain participation require a substantial commitment of time by agency representative(s) who are knowledgeable and enthusiastic about EPSDT, sensitive to provider concerns, and skilled in interpersonal relationships. Although State agency personnel may spearhead provider participation campaigns, continuous efforts to maintain productive provider relations are best carried out by program staff at the delivery level. Regardless of the locus, provider recruitment efforts should stress benefits to the practitioner (e.g., increased financial stability and improved cash flow) and be straightforward about program requirements.



Three practices—which are not necessarily mutually exclusive—are effective in accessing providers and attracting them to the program:

- Enlist Provider Peers To Help With Recruitment Efforts—A peer group individual usually is effective in garnering support and enlisting participation because he can relate well to and is accepted by the target recruits. Fellow providers who are committed to the EPSDT program are well equipped to promote EPSDT's preventive care philosophy, to encourage providers to establish ongoing physician-patient relationships with EPSDT clients, and to move providers to develop appropriate health care utilization behavior by EPSDT patients.

Where the administering EPSDT agency is not a health organization or does not have physicians on staff, implementation of this practice will require a contract with individual physicians or linkage with a sister health agency that does have a physician staff.

- Involve Professional Societies And Organizations In Provider Recruitment—In most States, many providers belong to medical and dental societies. These societies provide a professional forum (through assemblies, committees, and publications) through which EPSDT can recruit providers, promote EPSDT in general, and address provider concerns. Specifically, EPSDT staff and physician peers can: (1) address local medical and dental society meetings to explain the program, answer questions, and enlist participation, (2) publish articles about EPSDT in provider association newsletters and include the name and telephone number of the program administrator or lead provider to whom inquiries can be addressed, (3) locate newly licensed or new-to-the-area providers through professional association directories, and (4) distribute informative brochures that demonstrate the benefits (to the provider and the patient) of participating in EPSDT.

In working with the professional societies, representatives of the administering agency must be prepared to deal with hostile audiences and must be sensitive to expressed concerns and suggestions.

- Recruit Providers Through One-To-One Contacts—The personal attention provided through one-to-one meetings between prospective providers and administering agency representatives provides an excellent opportunity to discuss the program requirements and allay provider concerns. The benefits of this practice can be best realized when: (1) providers are visited in their own offices, (2) providers are provided with brief explanatory materials about EPSDT, (3) providers are invited to maintain continuous communication with the administering agency staff (preferably a designated liaison person familiar with that provider) to discuss problems or concerns as they arise, and (4) the administering agency is diligent and timely in responding to provider inquiries and complaints.

These efforts can be performed by agency staff or through agreements with health organizations, independent practitioners, or sister health agencies.



Either singly or in a combination, these practices will help the administering agency enroll sufficient providers to render the required variety and volume of care and, ultimately, will afford clients a greater choice of providers committed to establishing ongoing health care relationships of the practices described above. One-to-one recruiting should be most effective, particularly if conducted by a provider peer, because it provides the best opportunity to: (1) establish fruitful ongoing relationships, (2) discuss the parameters, requirements, and expectations of EPSDT, and (3) address provider concerns.

Once sufficient providers are recruited into the program, the administering agency's attention turns to maintaining provider participation. The following effective practices are directed toward that end:

- Establish Ongoing Communication Between Providers And Program Administrators—Continuous dialogue with participating providers is essential. It suggests to providers that their efforts are appreciated and that EPSDT is indeed important—thus bolstering provider enthusiasm and support. Ongoing communication also provides a vehicle to: (1) disseminate information about new program developments and revised policies or procedures, (2) respond to provider complaints, problems, or questions, (3) transfer technology and report on effective practices, and (4) identify strategies for program improvements.

Ongoing provider communications can be facilitated by regularly visiting providers in their offices, distributing scheduled newsletters, inviting providers to attend agency functions, and drafting understandable (plain English) program manuals and instructional materials. The administering agency also may establish a Provider Advisory Group to stimulate two way communication between providers and the agency.

- Train Providers And Their Staff—Initial orientation and periodic training (e.g., seminars or workshops) provide an excellent opportunity to assure uniform understanding of EPSDT's mission and associated requirements and to address common areas of concern or technical problems among providers (e.g., billing and claims processing procedures, developmental assessment screening, case management activities such as client appointment making and referrals for diagnosis and treatment).

Training effectiveness will be enhanced when the agency: (1) develops well-structured—but not overly didactic—curriculum which incorporates group discussions and exercises into each event, (2) uses experienced trainers and peers, (3) conducts small group training at the local level, (4) obtains continuing education credit by the American Medical Association, American Dental Association, or State or local schools for allied health or business professionals. It is advantageous to have authoritative State or county staff attend the training to answer policy questions as they arise.

- Pay Providers Promptly And At Realistic Rates—Adequate reimbursement rates and timely payments are probably the most significant factors in retaining provider participation in EPSDT. To increase provider satisfaction the State should consider: (1) paying or approximating usual, reasonable, and customary (URC) rates for diagnosis and treatment services, (2) paying higher rates for EPSDT medical services than for equivalent Medicaid services (in recognition of the additional burden created by case management and the comprehensiveness of the screening examination), (3) developing innovative capitation rates for comprehensive care providers, (4) requiring providers to bill for services within 30 to 45 days of delivery, and (5) improving the claims processing system to ensure that providers are paid within 30 days.

The type of extent of provider maintenance activities a State or county selects depends on the available resources and on the existing relationships with and attitudes of providers. Ongoing one-to-one contact with providers always is most effective for building rapport and sustaining enthusiasm, particularly with new or nonsupportive providers. Ongoing contacts can be conducted by State or county staff, by contract or staff, or by staff of a sister health agency. Each liaison should be responsible for a specific region so he or she can develop personal rapport with providers. If tight budgets restrict the frequency or even the feasibility of one-to-one contacts, provider advisory groups, to which individual providers direct problems and suggestions, also can identify widespread problems that indicate needed program changes. A newsletter is nearly always a good communication vehicle. It is relatively inexpensive and can maintain contact with providers between infrequent personal contacts or training seminars. A newsletter alone, however, is not sufficient to fulfill the need for communication between program administrators and providers.

Training providers and their staff is mutually beneficial to the agency and providers. It provides an opportunity to promulgate EPSDT requirements, improve program administration and care, or address provider concerns in a uniform and less costly manner than one-to-one provider contacts.

Finally, responding to problems associated with inadequate or slow payment is difficult in light of today's fiscal climate. Increasing payments is costly and reimbursement rates for EPSDT services now are unlikely to equal the rates charged self paying and other non-Medicaid patients. Therefore, States should concentrate on decreasing the turnaround time for processing claims, recognizing that this is tied to difficult personnel and data processing problems. If claims processing improvements are beyond the control of EPSDT staff, then States may need to focus on non-financial barriers to sustain provider support.

## GOAL 2: ENCOURAGE BROAD-BASED COMMUNITY INVOLVEMENT IN EPSDT

EPSDT activities do not occur in a vacuum. Even small programs affect thousands of lives daily (local administrators, allied health agency staff, providers, clients and their families) and compete for scarce public dollars and attention. Therefore, program policy, goals, service delivery structures, and administrative strategies must be well planned and clearly articulated. EPSDT program plans should reflect operational realities, should make maximum use of limited resources, and should be supported by all involved parties, including the community at large.



Ongoing involvement in planning by key agencies and community leaders helps develop solid, workable programs, builds broad-based support, and establishes accountability for program implementation. The following practices help bring about such support.

- Require Each County Or Local Office To Submit An Annual Plan To Serve As A Basis For Developing A Statewide EPSDT Plan—Comprehensive annual program plans and the processes required to create them offer these advantages: (1) promote rational allocation of resources to meet priority needs and to reflect operational realities, (2) create a vested interest in EPSDT by participants in the planning process, (3) serve as a basis for monitoring program progress, and (4) provide a vehicle for promoting the program and articulating its goals and objectives.

To ensure consistency among county plans, the State agency should provide guidelines for the planning process and plan content and format. At minimum, counties should be required to involve local allied health and human service agencies, planning agencies (such as health systems agencies or county planning agencies), providers, and consumers. Each plan should contain: (1) an assessment of last year's performance, (2) a needs and resources assessment, (3) screening, diagnosis, and treatment goals and objectives, (4) a description of how the program will be administered (e.g., provider network and case management activities), (5) planned linkages and collaborative efforts at the delivery level, and (6) resource requirements for the forthcoming year (i.e., dollars and staffing). The planning process should allow sufficient time to analyze each local plan before all are folded into the Statewide EPSDT Plan. (See Chapter III for additional information about the practice.)

- Involve Collaborating Agencies In Developing Program Plans And Strategies—Allied agencies that are invited to participate in program planning and strategy development may bring to bear additional expertise and usually will support initiatives they helped develop. Collaborating agency input to and concurrence on draft and final plans yields improved communication and cooperation and reduces the chances for subsequent disagreements.

Collaborating agencies may participate in the planning process collectively through a committee process or by working individually with the administering agency. Participating agencies should be involved from the earliest stages of the process, so they can develop a sense of ownership and make meaningful contributions to shaping the final product.

- Solicit Ongoing Input From Providers, Consumers, And Other Interest Groups Through A Standing Advisory Council—A Standing Statewide Council of local program officials, consumers, providers, third-party payers, private industry and special interest groups (e.g., Children's Defense Fund, Muscular Dystrophy Association) allows participants to

provide regular input on policy and planning matters. This body serves as a sounding board for new ideas, provides access to community expertise, and encourages the development of staunch program advocates.

The Council should meet at least quarterly with a prepared agenda distributed to members in advance. The State Agency Director and EPSDT Coordinator should take an active role in the meetings and provide supportive services (e.g., preparing minutes and providing travel reimbursement). The Provider Advisory Group, described earlier in this chapter, may be a subcommittee of the Council, reporting provider concerns to the full Council at regular intervals.

- Conduct Public Hearings Before Promulgating Or Modifying Major Policies—Public hearings offer a forum for many individuals and organizations not otherwise involved in program planning. Hearings provide an opportunity for the State to hear of potential problems that necessitate changes in the plan, and for the community to become educated about the program and to decide how and whether to support it. Public hearings also reflect positively on the State agency, suggesting willingness to undergo public scrutiny and debate. Examples of topics for such hearings include Annual EPSDT plans, fee schedules, developmental assessment protocols, and periodicity schedules.

To assure large and representative turnout, the purpose, content, time, and location of the hearings should be advertised in prominent newspapers, on radio or television public service announcements, by posters, and through letters of invitation to key associations and individuals. Agency policymakers should be present at the hearings to respond to questions, and the media should be invited.

These four practices are not mutually exclusive. All require that the administering agency (1) consider suggestions and concerns provided by community representatives and (2) respond honestly to differing if not conflicting interests. These practices are a sound investment in improved program responsiveness and community support.

### GOAL 3: DESIGN ADMINISTRATIVE PROCEDURES THAT FOSTER SMOOTH PROGRAM OPERATIONS

EPSDT is more than individual providers serving individual children. It is a Program that requires inter-governmental administrative systems and mechanisms such as: (1) a communications network to transfer technology among EPSDT program staff, (2) minimum uniform program standards to assure equitable program operations, and (3) monitoring and control systems to assess ongoing program performance.

As with any complex venture, staff must have a common understanding of program priorities and operational requirements. Program staff should have an opportunity to share their experiences, resulting in technology transfer (e.g.,



effective practices) among jurisdictions, in enhanced staff morale, and in increased staff investment in EPSDT. The following practices facilitate the establishment of an effective communication network:

- Establish A Statewide EPSDT Hotline—If local EPSDT staff have access to a toll free telephone line "manned" by an authoritative State representative, they can: (1) receive timely responses to questions relating to program policy and operational requirements, (2) obtain referrals to sources of needed information, and (3) hold conference calls with staff from other localities or with health care experts to facilitate problem solving and technology transfer. (The hotline also may be used by individuals seeking general information about the program, e.g., eligibility requirements, where and how to receive care.)

The hotline may be staffed by a single full-time individual, by several staff who rotate on schedule, or by volunteers (who have been well trained and who have access to State EPSDT officials). Needless to say, the staff must be knowledgeable about program requirements and EPSDT's operational environment.

- Develop A Statewide EPSDT Newsletter Or Information Memoranda—Newsletters and memoranda are excellent mechanisms for disseminating information about: (1) program priorities, (2) changes in State or Federal requirements, (3) effective practices, (4) general information about child and preventive health care, and (5) answers to questions pervasive at the operational level. Such publications also promote a sense of a "professional community" and program purpose, thus increasing staff morale.

Newsletters should be distributed regularly and should balance serious didactic discussions with light, morale generating articles. One local staff or maternal and child health expert should be invited to contribute an article for each publication.

- Conduct Periodic Training Workshops And Conferences—Training events and conferences are effective communication media providing a forum to: (1) transfer clinical, management, and financial information, (2) provide technical assistance in mass to programs with similar needs, (3) explain new program policies and regulations, (4) identify common and persistent operational problems, (5) obtain feedback on State directives and proposed solutions to problems, and (6) facilitate group problem solving and decision making. Conferences also offer EPSDT staff an opportunity to exchange ideas and experiences informally, thus promoting collegiality and a sense of purpose.

These practices require staff and monetary resources; however, each may be implemented on a scale ranging from spartan to grandiose. For example, the hotline can be open all day or for only a few hours each day and staffed by full-time employees or volunteers; the newsletter may be developed by volunteers (e.g., graduate students in journalism or public health) or by full-time staff and may be

four mimeographed sheets or a 20 page glossy; training and conferences may be conducted more or less frequently, on workdays or weekends. Each jurisdiction must assess its own resources to determine the most practical approach.

The implementation of uniform statewide program standards is the second requisite to facilitate smooth program operations. It is important in both county and State administered programs to ensure equity of services across the State. Standardization promotes efficiency since major program design can be done once rather than individually and independently by each operating unit. Finally, the existence of standardized minimum criteria provides a basis for monitoring program performance. Local programs may view uniform standards as infringements on their autonomy. However, standards ensure equitable access to minimally acceptable levels of care and help each locality avoid "reinventing the wheel." It is thus mutually beneficial to the State, local jurisdiction, and clients.

In developing uniform program standards, the State must be aware of local capabilities and resources and must not unduly limit local flexibility in responding to unique needs. The following practices will develop minimum statewide standards while respecting the needs and limitations of local programs.

- Establish Standard Screening And Developmental Assessment Protocols—Standard screening and developmental protocols assure that all EPSDT clients receive the minimum required services by prescribing the procedures to be followed by providers in conducting assessments. Protocols also provide a basis for uniform reporting and performance monitoring. (Note that comparisons of local performance is meaningless if each locality provides different services or reports data in a different manner.)

Protocols should be developed through consultation with providers, allied health agencies, and consumers. Providers should be trained to use the protocols particularly if they reflect significant differences from prior practices.

- Develop A Standard Case Management/Client Tracking Information System—When case management and client tracking are uniform statewide, the State will find it easier to monitor and evaluate program performance, develop plans, and assure that children do not become lost in the system. Providing each locality a standard case management system is a form of technical assistance (since many do not have the technical capacity or financial resources to develop a system alone) and will reduce total developmental costs.

A uniform case tracking system is difficult to design and implement when local staff and system capabilities vary widely. It may be necessary for the State to design more than one system to reflect the diversity of needs (e.g., a manual and automated system design). The system should not be unduly burdensome to counties with wholly or predominantly manual systems or unresponsive to counties with modern computer capacity. Before attempting to design a minimum tracking system, the State should assess local system capabilities and catalog current case management procedures.



- Develop Standard Reports To Monitor Program Performance—A standard county and local office reporting system assures the State adequate data for monitoring individual programs and to compare across programs. Used as a management-by-exception tool, monitoring systems highlight problems and exemplary performances that deserve further attention and ultimately may save staff time and financial resources.

The reporting system should be based on the uniform case tracking system (discussed previously), that is, aggregated data for reports should be generated from the case tracking system. State-supervised county administered programs should prescribe a minimum data set rather than an entire reporting system to allow more sophisticated counties the option of reporting additional information (perhaps useful for applied research or program promotion). Scheduled and timely feedback should be provided to each county or local office so that they also can learn from the system. This also should reduce resistance to the system by local staff and increase the timeliness and quality of reported data.

- Assign Staff To Serve As Chief Liaison To Specific Programs—A staff individual may be designated the State's primary liaison or ambassador to local programs within regions. The ambassador should monitor program performance, help improve program operation, and serve as the focal point for communications. Specifically, he/she should review monitoring reports, conduct on-site visits at least semi-annually and as needed, and keep in constant telephone communication with each program. This will enable the ambassador to establish personal rapport with delivery level staff and to become knowledgeable about program operations. As a result, he/she will be in a better position to: (1) identify potential problems before crises develop, (2) determine training and technical assistance needs, (3) provide technical assistance, and (4) assure consistency in implementing State policies.

For this practice to be successful, the ambassador must balance carefully the helper and program advocate role with the monitor role.

- Conduct Joint Site Visits To Monitor Collaborative Activities—When EPSDT involves linkages with other agencies, the administering agency's monitoring and technical assistance responsibilities extend to entities not otherwise within its purview. Of course, monitoring responsibilities should be addressed in the interagency agreement(s), whenever possible, monitoring (particularly on-site assessments) should be conducted jointly by the EPSDT and collaborative agency to increase the likelihood that problems will be resolved constructively and to promote corrective actions that are mutually beneficial. Joint monitoring efforts are politically sound and strengthen the ongoing symbiotic relationship between the collaborators.

- Employ Physicians And Other Health Care Professionals To Monitor And Assist Providers—Monitoring providers requires tact and expertise and usually is best done by a provider peer. Providers usually will be receptive to guidance from a peer about how to improve screening, diagnosis, and treatment services.

Provider profiles (generated by the claims processing system) initially identify providers who do not meet program expectations. Subsequently, a more indepth assessment should be conducted to understand the reasons for apparent deviations, to assess compliance with professional standards and EPSDT requirements, and determine whether corrective action is required to improve the delivery of care. The State should develop a protocol to guide documentation reviews and on-site visits, thereby assuring uniform, equitable assessments. Resources permitting, on-site visits should be conducted at least annually to all participating providers who serve a significant proportion of the EPSDT population.

Where the administering EPSDT agency is not a health organization or does not have health care professionals on its staff, it can contract with individual health care professionals or link with an agency that does have appropriate provider staff. These individuals may operate under county auspices in the State supervised EPSDT program.

The monitoring practices described above are not mutually exclusive and, indeed, are most effective when implemented in concert. Uniform data are required by administering agency monitoring staff to assess program performance and by the site visit team members as background information to highlight potential problem areas or exemplary practices. Site visit assessments conducted with collaborative agency staff by health care professionals provide a means for verifying and explaining variances suggested by reported data. The expertise and cooperation of a collaborative agency or provider peer facilitates monitoring. Combined, these practices provide a logical basis for: (1) altering State policies and procedures, (2) targeting technical assistance, and (3) promoting program accomplishments or effective practices.

Data from routine reports and on-site assessments can be compared across localities to obtain a picture of overall State performance. Statewide performance can be compared to national data to identify program strengths and weaknesses and to assess the potential for transferring new techniques from other States.



**SECTION B**

**EFFECTIVE PRACTICES IN  
OUTREACH AND INFORMING**



## SECTION B

### EFFECTIVE PRACTICES IN OUTREACH AND INFORMING

Outreach is an essential aspect of EPSDT, although States have considerable flexibility in organizing and conducting the following activities that comprise this functional area: (1) promoting EPSDT and distributing promotional materials, (2) conducting case finding, (3) informing eligible children (in writing or face-to-face), (4) reinforming eligible non-participating children, and (5) notifying eligible children when periodic exams are due.

Within varying regulatory, environmental, and budgetary constraints, States usually organize outreach and informing activities around two primary goals:

- Generate widespread community support for the program to interest potentially eligible persons in participating
- Inform each eligible individual about the availability and benefits of the program

The remainder of this section identifies effective practices for reaching these goals.

#### GOAL 4: CONDUCT COMMUNITY OUTREACH TO GENERATE WIDESPREAD COMMUNITY SUPPORT AND ATTRACT ELIGIBLE INDIVIDUALS TO THE PROGRAM

Basically, outreach is a way to publicize EPSDT's existence to potential clients and elicit their participation. Outreach can take the form of communitywide promotions or can target circumscribed subpopulations. Outreach messages may stress general health and prevention concepts or EPSDT itself. Regardless of their scope or specificity, outreach activities should strive to promote good health as an enjoyable and rewarding pursuit. The following practices use different media (e.g., visual, print, events) to improve outreach efforts.

- Develop Television And Radio Public Service Announcements—Public service announcements (PSAs) convey both factual and emotional messages quickly and often can transcend literacy barriers. PSAs can reach a large population at any given time. These announcements are most effective for children and adolescents when national celebrities (e.g., singers, actors, athletes) participate.

Nearly all radio and television stations provide free air time for PSAs. Production costs also may be defrayed if: (1) local television and radio stations or university film departments donate time and materials or (2) the EPSDT message can be linked with another health or public service (e.g., prenatal care) and the production costs shared by EPSDT and other sponsors. Finally, States may seek assistance in producing PSAs from HCFA's Central Office, which maintains full service audiovisual production studios and a file of existing PSAs.

- Produce Short Films—Short films which dramatize the benefits of EPSDT are an effective means of reaching potential clients statewide in movie houses (as a short subject prior to the feature film), in hospital clinic and welfare office waiting rooms, in literature distribution sites, and in other natural gathering places.

Films and necessary projecting equipment can be distributed by a central State resource center to reduce costs and make resources readily available throughout the State. Production requirements and methods of defraying costs for films are essentially the same as for PSAs.

- Appear On Talk Shows—Television and radio talk shows with a public service emphasis provide an effective forum for explaining EPSDT's purposes, benefits, scope, and eligibility requirements to a broad segment of the community.

States considering this technique might wish to include a physician in the presentation to affirm the program's medical credibility.

- Use Print Media—Print materials can be targeted effectively to specific population groups (adolescents, small children, non-English speaking individuals) and include such diverse items as posters, brochures, pamphlets, flyers, coloring books, buttons, and bumper stickers.

Print materials should be attractive, readable, and current. Production costs may be defrayed by gaining donated time from advertising and public relations firms or from graphic arts schools. Materials can be displayed at linkage agencies, businesses, provider offices, public transportation vehicles, libraries, recreation centers, housing projects, grocery stores, community education and training act (CETA) projects, schools, Parent-Teacher Association meetings, day care centers, head start projects, and job corps sites.

- Conduct Outreach Seminars—Outreach seminars afford an opportunity to explain program purposes, eligibility requirements, and benefits in detail and to answer questions and discuss the program with individuals who are especially interested.

Seminars may be conducted wherever a significant number of potential clients can be found, e.g., hospitals, postnatal care units, family planning and well child clinics, and housing authority meetings.

- Organize Special Events—Special events and campaigns may take the form of Health Fairs, EPSDT Week, Child Health Prevention Campaigns, or Health Days. The primary purpose of these events is to focus attention on and generate interest in health care prevention and EPSDT.

This is best accomplished through multimedia activities which generate excitement and are fun while, at the same time, deliver a substantive message about EPSDT. Examples of such activities are: (1)



poster design campaigns, (2) performances by celebrities and nationally recognized personalities such as athletes or characters appealing to children e.g., Mickey Mouse, clowns, (3) films about health care and EPSDT, (4) amusement rides and carnival events, (5) plays and shows conducted by children, (6) dissemination of literature and public debates about health care and EPSDT, and (7) live radio or television coverage. These activities may be conducted in one central location (e.g., health clinic) or at key locations throughout the community/State (e.g., shopping centers, schools). It is invariably helpful if the campaigns are supported publicly by a popular political leader (e.g., Governor, County Executive, legislative representative).

- Develop A Cadre Of Effective Outreach Workers—Successful outreach depends on a cadre of enthusiastic, appropriately trained individuals to conduct seminars, distribute materials, and answer inquiries about the program.

Few agencies, however, have sufficient outreach workers on staff. Staff may be borrowed through collaboration with such agencies as maternal and child health programs (e.g., Women, Infant and Children; Children and Youth) health departments (if the SSA is a welfare or social service agency), social service or welfare agencies (if the SSA is the health agency), school systems, family planning programs, housing authorities, and CETA projects. Some States and localities have employed AFDC recipients to conduct outreach, and some have contracted out all or part of the outreach function.

Ideally, States would employ most of these practices, however, this may not always be feasible. The scope of effort and combination of practices selected by each State depends on: (1) the characteristics and likely locations of target groups, (2) the extent to which service capacity exists to handle new clients, and (3) the dollars, staff, and other resources from all sources that the State can marshal for outreach activities. Involving providers, consumers, and local businesses in the design and implementation will help stretch limited resources and further community support. To this end, States or counties can use advisory groups to generate support from foundations, church and service groups, educational institutions, and other community and provider groups. In particular, local businesses and industry (e.g., Chambers of Commerce, industry councils) have proven willing to donate time, money, and materials to as worthy a goal as child health. Linkages with other State and local agencies are helpful. Developing broad community involvement requires that the agency commit enthusiastic, effective liaison staff to the effort.

#### GOAL 5: INFORM ELIGIBLE INDIVIDUALS ABOUT THE PROGRAM TO INCREASE THEIR UNDERSTANDING AND SECURE THEIR PARTICIPATION

The personal contact of face-to-face discussions provides an excellent opportunity to explain preventive health and EPSDT, and to respond to individual client needs. The following are practices to improve the effectiveness of informing. The first six practices pertain to face-to-face contacts whereas the latter two are directed at written notifications. (See Chapter III for additional information about face-to-face informing.)



- Maintain A Core Of Trained Outreach Workers—Face-to-face informing will be effective only if workers have reasonable case loads and are knowledgeable in preventive health care, enthusiastic about EPSDT, and talented in interpersonal relations and communication.

Informing workers can be drawn from the administering agency, from collaborating agencies, or from a contractor. These personnel can be EPSDT case managers or special informing workers and trained as public health nurses, financial workers, social workers, or community workers. AFDC recipients also may function quite effectively in a one-to-one informing capacity, establishing rapport with peers and relating their personal experience with EPSDT. Their willingness to represent the program can be strong testimonial to its merit. Most States may need to draw staff from a number of sources and many of these staff may have competing other duties. Worker effectiveness is greater, however, if EPSDT is the individual's sole or primary responsibility.

- Develop A Statewide Informing Protocol—A standard protocol will assist staff by serving as a guideline for the informing interview. To ensure that all points are discussed in interviews with all clients these protocols should be designed as a checklist, rather than a structured questionnaire, to allow staff flexibility in conducting the discussion and to allow interpersonnel relations to flourish.
- Inform Clients At Eligibility Determination—Informing clients immediately after they have applied for public assistance or Medicaid is the most efficient approach of conducting face-to-face contacts. The informing function may be performed at the social services center by the eligibility determination worker or by a specialized EPSDT worker. Specialized workers often are more effective because they can devote their energies to enthusiastically promoting EPSDT; they can create a more relaxed atmosphere and be more positively perceived by clients if they are not involved in eligibility determination.

A major drawback of this practice is that applicants, usually in a serious or crisis situation, may fear being denied assistance; therefore, clients may not be particularly interested in preventive health care or may apathetically agree to participate in EPSDT, believing that doing otherwise would endanger their chances of receiving financial assistance. In the latter case, clients often do not appear at scheduled appointments.

- Conduct Home Visits To Inform Clients—Once in their home environment, with their most urgent assistance needs met, clients usually are more receptive to discussing the program and its benefits. Although some clients may be defensive, viewing the interview as intrusive, many will ask questions and consider enrolling in the program. Home visits also are effective because of the single focus of the interview and because the worker can meet the family, assess its needs, and provide personal attention. Home visits can be conducted to inform clients who have just become eligible, who have been recertified as eligible, or who are undecided or have declined services.

Workers also can conduct individual informing interviews at hospitals. Through this technique, which is particularly effective with obstetric patients, clients are contacted at an especially receptive time and enrollment potential is high.

- Distribute An Information Packet For Informing Potential Clients—A packet distributed during informing contacts enables eligible families to review pertinent information about the program after the interview. Information packets may be distributed at eligibility determination, at the informing interview, or during home visits. The packets are an ongoing reference source to answer questions about program procedures and requirements. The packet should contain information describing: (1) the benefits of preventive health care, (2) EPSDT eligibility requirements, (3) service and care benefit coverage, (4) available support services (e.g., transportation), (5) participating providers, (6) each client's case management's responsibility (e.g., scheduling and keeping appointments), (7) appropriate patterns of health care utilization, and (8) names and telephone numbers of agency staff to contact when questions or problems arise. Materials should be designed for non-English reading clients, where necessary.
- Monitor Worker Performance—Regardless of where informing is conducted, staff performance should be monitored: (1) to ensure that all clients receive complete and consistent information about the program from enthusiastic and helpful individuals and (2) to promote accountability among staff.

Performance can be measured qualitatively against the approach and procedures prescribed by the standard protocol. It can be measured quantitatively by comparing the number of families informed and enrolled against individual and program goals. Consistently low performance or enrollment rates may indicate morale problems, an inappropriate approach, or the need for additional staff training.

- Personalize Written Notification—Personalizing mailed materials, such as periodicity notices, increases the likelihood that they will be read and stimulates client participation in and enthusiasm for EPSDT. This may entail writing the client's name on the envelope (automatically by word processing or computers, or by hand) or it may involve writing a brief note at the bottom of a form.
- Coordinate Mailings Of EPSDT Informing Materials With The Issuance Of Cash Assistance Checks—Arranging the mailing of informing materials to coincide with or slightly precede the receipt of cash assistance checks will capitalize on the client's anticipation and increase chances that materials will receive attention. Experience suggests, however, that informing materials often are discarded unread when they are received in the same envelope as the assistance check. The envelope used to mail EPSDT informing materials should be the same as the envelopes used to send assistance checks.

These practices may be used alone or in combination. Where funding and the potential for community assistance are especially limited, a standard informing protocol, an information packet, worker monitoring, and worker training are the minimum foundation for this program component. Beyond this, States and counties may select practices from a broad continuum of cost and staffing requirements. On one end of the scale, home visits can be made to all eligibles—a most effective but costly option. At the other end of the spectrum is informing all clients (by the eligibility worker) at intake—an option that requires fewest staff, but which results in low enrollment rates. As a middle of the road strategy, the agency may identify certain cohorts of the EPSDT population (the undecided, or newly recertified) for home visits, while informing all others at intake. Likewise, the amount of time spent with each client and the level and frequency of worker training depend on the level of available resources.



**SECTION C**

**EFFECTIVE PRACTICES IN CASE MANAGEMENT**





## SECTION C

### EFFECTIVE PRACTICES IN CASE MANAGEMENT

Case management is an integral component of the EPSDT program, providing the mechanism to ensure that: (1) children are screened and rescreened, (2) medical problems identified by the examinations are treated, (3) children are linked with the health care delivery system on an ongoing basis, and (4) children receive transportation and support services. The administrative activities required to operate a case management system in the health and medical assistance environment are complex. EPSDT case management requires diligent client tracking and documentation through an information system. A poor client tracking information system is the Achilles heel of case management overall.

This section describes practices that facilitate the attainment of two case management goals: (1) organize case management activities to ensure that clients receive needed services and (2) develop a management information system to support case management activities.

#### GOAL 6: ORGANIZE CASE MANAGEMENT ACTIVITIES TO ENSURE THAT CLIENTS RECEIVE NEEDED SERVICES

Because of their complexity, EPSDT case management activities can be time consuming and labor intensive, and often are considered burdensome. State and local case management approaches vary and are shaped significantly by environmental factors such as the: type of administering agency, staffing patterns, size of the EPSDT population, the State's geography and transportation network, and the agency's philosophical outlook. In any event, case management activities must maximize the efficient deployment of agency resources while monitoring client status to ensure the provision of care. The practices identified below are directed toward these ends. The first two practices reflect different philosophies of case management and the latter two may be used regardless of the agency's approach.

- Employ Intensive Case Management Throughout The EPSDT Process—Intensive case management requires the case manager to serve as an ombudsman or facilitator by taking active measures on behalf of the client to ensure the delivery of care and by concurrently monitoring the status of each case. Specifically, the case manager should: (1) arrange for screening examinations and required support services, (2) confirm the appointment with the provider, (3) remind the client of appointment date and arrangements for support services, (4) follow-up on screening examinations, (5) reschedule missed appointments and rearrange required support services, (6) make referrals for subsequent care, (7) confirm appointment with the provider, (8) arrange for required support services, (9) follow-up on each subsequent diagnosis and treatment visit, and (10) explain examination results and the continuing need for treatment to the client throughout the process, where necessary.

The major advantages of this approach are that it helps ensure that clients maintain their program commitments (e.g., keep scheduled appointments) and that the required treatment is obtained. Continuous and timely case monitoring also may prevent recalcitrant clients from dropping out of the program and may improve provider relations and participation by reducing appointment "no-show" rates.

Intensive case management requires the use of turn-around referral forms and telephone contacts with providers and clients to track the status of cases on a timely basis. Providers may perform some of the case management functions (e.g., referral to and follow-up on diagnosis and treatment services) to supplement the significant agency staff resources required to implement this practice. (See Chapter III for additional information on intensive case management.)

- Foster Client Responsibility For Case Management Activities—The antithesis of operating an intensive case management system is to develop an approach that promotes client and family responsibility for ensuring the delivery of care. As part of this effort, clients are responsible for making, changing, and keeping initial and follow-up appointments; arranging for support services; adhering to a medical regimen as prescribed in a treatment plan; and proper utilization of health care resources.

Agency staff in this practice serve more as educators than as case managers. They are responsible for helping clients understand the need for preventive and continuous primary care, the EPSDT process and requirements, the need to adhere to a health management plan, and the health care delivery system.

This approach ultimately should require fewer resources than the intensive case management approach. Monitoring case status is conducted retrospectively (as opposed to concurrently) through the claims processing system. By avoiding the dependence on the case manager, this approach also promotes the client's abilities to enter and stay within the medical system to ensure ongoing care after EPSDT eligibility lapses. In addition, the approach enhances a client's self-sufficiency—a major goal of most social service programs.

- Develop A Cadre Of Trained Case Managers—The appropriate staffing for EPSDT is a primary requisite to ensure that the program meets operational mandates and legislative intent. While many EPSDT programs cannot staff all functions (e.g., outreach, informing, case management) with full-time specialized workers, EPSDT should at least be a separate organizational unit staffed with individuals committed to EPSDT.

Administering agencies may supplement staff resources by linking with other agencies. As indicated previously, providers can perform part of the case management function, since they already are involved in the case and can make appropriate referrals. Volunteers can arrange support services. Client peers can establish continuous



rapport with clients and serve as a model of EPSDT program effectiveness. States may also consider contracting with private or non-profit organizations to perform case management functions. While the Federal reimbursement rate is lower for contracts than for in-house staff (50 versus 75 percent) the contractual mechanism may provide expertise and first hand experience in case management that can not otherwise be garnered through the civil service system. Moreover, this mechanism commits agency resources only for the contract period (annual) as opposed to staffing which involves a more long term commitment of resources. This allows administering agencies greater control and flexibility for subsequent program modifications (e.g., reductions or expansion of case management resources).

As with outreach workers, case managers must be appropriately skilled in interpersonal relations and receive training in preventive health care and EPSDT operational requirements.

- Assign Permanent Case Loads—Assigning case managers permanent regional case loads promotes effective case management, reduces travel costs and staff time for home visits, and enhances rapport between clients and case workers. Workers will be able to develop relationships with families, enabling them to identify and address client needs before crises develop. Personal attention helps ensure that clients do not become "lost" in the system, that they receive required services, and that they feel comfortable asking questions or discussing problems. Rather than feeling battered among several strangers, clients may feel more vested in the program when they receive ongoing individual attention. When cases are assigned permanently and the caseload is manageable documentation is likely to be thorough and consistent. Permanent case loads may positively influence staff morale as case managers may be able to see improvement in clients' health status.

The organization of case management activities will be influenced by the approach adopted by the administering agency regarding the client's potential for assuming responsibility in the EPSDT process. The agency's internal and external resources also will dictate the type and level of case management functions. The more EPSDT is viewed as an agency priority (as reflected in the organization structure of the program and in the staffing approach selected) the more likely that the EPSDT program will be successful in addressing client needs.

#### GOAL 7: DEVELOP A MANAGEMENT INFORMATION SYSTEM TO SUPPORT CASE MANAGEMENT ACTIVITIES

All State and local case management activities must be supported by an information system to facilitate worker effectiveness and to improve administrative operations. These systems may be manual, automated, or as the case in over 20 States, a combination of manual and automated systems. The specific capabilities and the detailed design of a State's or local office's system reflects the agency's: (1) case management philosophy, (2) size of the EPSDT population, (3) administrative processes, (4) staffing pattern, and (5) computer capabilities.

Required forms, data flow, and output requirements for an EPSDT case management information system (CMIS) are noted throughout this chapter where they support the attainment of a specific goal. The purpose of this section is to highlight the functional capabilities or system modules of an effective EPSDT case management information system.

- Identify Eligible Clients And Initiate The Necessary Case Documentation—The CMIS should be designed to support the requirements of the informing process. Specifically, the system should: (1) identify all eligible EPSDT recipients, (2) notify Agency staff of clients eligible for service, (3) produce written notification to inform eligible clients of EPSDT services and its benefits, (4) generate the information required for completion of forms used in the informing process by Agency staff, e.g., screening and supportive service referral forms, health management plans, (5) establish an EPSDT Master Case File containing data on the client's demographic characteristics, eligibility status and participation status, and (6) periodically inform clients of their eligibility status.

The source of the information for the above is obtained from the Medicaid eligibility master file and from Agency staff through the informing process.

- Track Clients Through The EPSDT Screening Examination—The second important capability of the CMIS is to follow clients requesting screening or support services from the time of the initial request until treatment is rendered for any medical conditions identified during the screening process. Specifically, this component of the CMIS should: (1) identify basic information about the screening exam, e.g., date of exam and provider, (2) delineate provisions made for supportive services, (3) create a "tickler" system to remind the case manager and/or clients of scheduled appointments and supportive service arrangements, (4) verify whether or not the screening examination was conducted, and (5) identify all referrable medical conditions requiring diagnosis and treatment.

There are three basic information sources required to support this capability: (1) the EPSDT master case file, (2) client information obtained from the Agency staff regarding the proposed screening encounter, and (3) follow-up on the screening examination itself. There are several alternatives to document and follow-up on the screening examination. These include using a turnaround referral form, (5) a turnaround health management plan, a combination of a turnaround referral and billing form used solely for EPSDT services, or the Medicaid claims form. All "new" information related to the screening process should be entered into the master file.

- Track Clients Through Diagnosis And Treatment—The Agency has various options or alternatives in the design and structure of this component of the CMIS in order to tailor it to specific Agency needs. For example, whether there is an intensive case management



system or if clients are primarily responsible for their own case management activities, whether or not providers are involved in the case management process, the size of the EPSDT eligible population, and the level of automation present in the Agency.

At minimum, this system component must retrospectively track diagnosis and treatment services provided. This can be accomplished by using the Medicaid claims processing transaction file and matching it against the EPSDT Master Case File. This component of the CMIS may also be used, as in the screening process, to support the appointment scheduling process for diagnosis and treatment services and to concurrently track the provision of care. In this case, a separate turnaround document (e.g., multipart referral forms or treatment plans) should be used which will provide more timely information than relying upon the claims processing system as the primary information source. Like the screening process, the Agency may desire to use this system component as a means to remind staff and/or clients of scheduled appointments and arrangements for supportive services.

There are three basic output requirements associated with this system component, regardless of the specific characteristics or operational features selected. These requirements include the production of: (1) follow-up reports to Agency staff regarding client's receipt of diagnosis and treatment services, (2) updates to EPSDT Master Case File regarding services received to support the development of client profiles, and (3) an EPSDT Provider File.

- Implement A Referral Tracking System To Determine Whether A Client Received Services Outside The Medicaid System—EPSDT clients often receive medical care which is not reimbursed by Medicaid and therefore, the information relative to the services they receive is not known by the Agency. These clients may be under the continuing care of a provider and therefore, may not require any EPSDT service until the next required screening examination as indicated in the periodicity schedule. Other clients may have received components of the screening examination such as vision and hearing tests or dental exams and therefore, may not require these components of the Standard EPSDT screening examination.

A tracking system should be developed as a component of the CMIS to identify the case provided outside the EPSDT system to EPSDT clients. This capability will allow the Agency to prevent duplication of services, maximize limited financial resources, and will enhance staff utilization by allowing them to direct their energies to EPSDT clients most in need. This information can be obtained by instituting data sharing agreements with major service providers in the area either by obtaining client encounter or referral forms or by obtaining aggregate computer tapes or client records.

- Provide Timely And Accurate Data To Case And Program Managers—As indicated previously, the case manager and/or informing worker requires up to date client information throughout the EPSDT process. At minimum, they need to have a listing of: (1) EPSDT eligible



clients, (2) clients requiring screening examinations based on the periodicity requirements, (3) scheduled EPSDT screening examinations, (4) client status regarding the delivery of screening examinations, (5) clients needing diagnosis and treatment, (6) client status regarding diagnosis and treatment services, and (7) certified Medicaid providers.

In addition to these case management reports the following additional reports are required for general management purposes to assess the overall effectiveness of EPSDT: (1) case response reports to determine the number and percent of EPSDT eligible clients who receive services, (2) case screening status reports to determine those who need a screening examination versus those who actually receive the examination, (3) diagnosis and treatment status reports similar to those indicated for case screening, (4) EPSDT client demographic profile reports, (5) aggregate diagnosis and treatment procedure reports for the EPSDT population, and (6) financial reports regarding screening, diagnostic, and treatment procedures.

The capabilities described above enhance the performance of the case manager and informing worker's routine duties by ensuring that eligible clients receive the required services. The degree to which these capabilities may be satisfied will vary among Agencies depending upon their information system capabilities and features and the case management approach employed. In revising the CMIS, the Agency should assess their information requirements and existing capabilities and then consult with clinical staff, program managers, and service providers to ensure that the CMIS will, in fact, meet operational requirements. In addition, the Agency should maintain contact with agencies in other jurisdictions to identify potential information system enhancements or technological changes which may be transferred.

**SECTION D**

**EFFECTIVE PRACTICES IN SCREENING,  
DIAGNOSIS, AND TREATMENT**



## SECTION D

### EFFECTIVE PRACTICES IN SCREENING, DIAGNOSIS, AND TREATMENT

Screening, diagnosis, and treatment are EPSDT's *raison d'être*. Without effective approaches for ensuring adequate medical and rehabilitative services, the practices identified in previous sections are of little value. To this end, States must provide a minimum screening package, all treatment services included in the State Medicaid Plan, and certain additional services related to hearing, vision, and dental care.

States also may provide EPSDT clients additional medical or remedial services not ordinarily covered by the State Plan. When screening and diagnosis uncover problems that require treatment beyond the scope of the State Plan, States must provide EPSDT clients with the names, addresses, and telephone numbers of providers willing to provide care at nominal or no cost. Health care resources are not limitless; yet a broad, statewide network of providers is needed to serve the EPSDT population and, so, States must rely on existing providers and on public and voluntary agencies.

Aside from striving for quality care, the EPSDT network must satisfy three other goals when providing services: (1) accessibility of care, (2) continuity of care, and (3) cost-effectiveness of care. This section identifies practices directed toward these three goals.

#### GOAL 8: INCREASE ACCESSIBILITY OF SERVICES

A primary focus of EPSDT is to link eligible children with a provider, i.e., to promote accessibility. Accessibility is affected at least by these factors: (1) number, type, and geographic distribution of providers, (2) ease with which clients can use the services (e.g., transportation modes and distances, provider hours and attitudes, cultural differences, processes for determining eligibility), and (3) client perceptions of their ability to enter the medical system and their attitude toward health care. Clearly, State and local efforts to promote EPSDT and to identify eligible clients contribute to client perceptions and, thus, impacts the accessibility of services. The following pages describe practices that enhance the accessibility of services.

- Contract With Health Departments Or Publicly Supported Clinics To Provide EPSDT Medical And Rehabilitative Services—Most communities have existing ambulatory health centers located near where the target population lives and which already provide care to EPSDT clients. Linkages with these clinics improve accessibility by: (1) increasing the number of service locations, (2) making it easy for clients to reach the facility, and (3) building on an existing relationship between clients and providers, thereby fostering client perceptions about the receptivity of providers and minimizing cultural and social barriers. For example, family planning clinics may be particularly effective in reaching the adolescent EPSDT population.



More importantly, most of these clinics provide comprehensive services and can meet most client needs except dental care; the latter can be provided through a referral or a subcontract.

Candidates for such arrangements include county health departments, Family Planning agencies, Maternal and Child Health grantees, Community Health Centers funded through the Rural or Urban Health Initiative, Migrant Health Centers, and Indian Health Service Centers. Contracts can be negotiated with these providers to provide screening only, screening and subsequent diagnosis and treatment, or parts of the case management function that do not have to be performed by the administering agency (e.g. identifying and informing).

Usually, at least several clinics will have to be involved to ensure thorough service and geographic coverage. The nature of the agreement and scope of care to be provided will vary among jurisdictions and will be influenced by several factors, including (1) the clinic's capacity to provide the services, (2) the extent to which clients already use the clinic for screening, diagnosis, and treatment for non-EPSDT services, (3) the extent to which the private provider network resists such arrangements and the degree to which their participation in EPSDT is needed, (4) the services already provided by the clinic without cost, and (5) resolution as to whether clients should have "freedom of choice" to select their own provider.

- Conduct Screening At Locations Frequented By The Target Population—EPSDT can improve accessibility by providing screening services at locations where clients are a "captive audience" or where they often are found. This will increase the number of children screened and, depending on how services are administered it may reduce the case management burden (specifically, arranging and following up appointments).

Examples of such locations are nursery, elementary and secondary schools; Head Start Projects, Job Corps Sites, housing projects, churches, recreation and teen centers, and shopping centers. Although schools and many government-sponsored pre-school educational programs previously had the staff to conduct parts of the screening examination, today's tight fiscal situation has reduced their capability to provide health care services. Therefore, it will be necessary to use private providers or staff from clinics or health departments to perform screening examinations at these sites. Appointments should be established in advance and screenings widely publicized to ensure a full turnout of eligible children and their parents. Eligible children and their parents should be reminded to bring their Medicaid cards or other acceptable forms of identification. The screening location should be linked to the Medicaid administering agency by telephone so that eligibility can be verified prior to the examination. Agency staff or volunteers should be on hand to assist providers in completing all necessary paperwork and in promoting preventive health care.

A variation of this practice is to provide initial screening for newborns while they are still in the hospital. This has the same advantages as discussed above. More important, the post-natal period is an opportune time to provide health education and to promote participation in EPSDT. It may be possible to contract with the hospital to provide the screening examination directly.

- Use Mobile Units For Screening Examinations—Specially equipped vans can bring services to clients. Mobile units are particularly effective in improving client access to care in rural or medically underserved areas. Mobile units can provide complete or partial screenings. For example, in localities with a dearth of specialty practitioners (e.g., hearing and vision, developmental assessment, dental), mobile units may be employed to provide only specialist care.

The operational requirements and alternatives associated with the mobile unit are similar to those of the practice described immediately above. The costs of operating a mobile unit sometimes can be offset by reducing client transportation costs. Private industry sponsorship (e.g., donation of a van), fund raising activities, and sharing the unit with other health agencies will help defray the costs of procuring, outfitting, and operating the unit.

- Operate Convenient And Comfortable Provider Facilities—As previously noted, the ease with which clients can obtain EPSDT services affects the accessibility of care. The following measures make services more convenient and comfortable for clients: (1) operate facilities in the evenings so that parents do not have to miss day time responsibilities (e.g., work, training/education, homemaking and child care), (2) employ bilingual staff if clients are not fluent in English, (3) use peers (e.g., other parents of EPSDT children) to perform non-medical tasks, such as appointment setting, transportation, and receptionist functions, (4) schedule appointments to minimize waiting time, (5) provide toys or conduct play activities in waiting rooms so that EPSDT children and accompanying siblings can be entertained and so that the parents can devote their time to receiving health education and to participating in the examination, (6) provide comfortable chairs and reading materials to make the wait informal and pleasant, (7) assist clients in completing forms and explain the purpose of the forms to reduce anxiety, and (8) explain the potential benefits of preventive rehabilitative services.

Naturally, not all of these measures are feasible in all cases. The appropriateness of each depends on the size of the facility and the characteristics of the EPSDT population served. To the extent that each is implemented, convenience and comfort of care are enhanced, as are client perceptions of accessibility of care.

In summary, the four practices described above increase accessibility of services by making services more convenient and comfortable to clients. All practices except the last require collaboration with private providers, health departments, or health clinics; further all can supplement the existing private provider network,



especially when providers are in short supply or maldistributed. Although screening examinations in mobile vans may not encourage continuity of care (unless the same practitioners subsequently provide diagnosis and treatment services), all four practices should increase the number of eligible children receiving some level of care under EPSDT.

## GOAL 9: PROMOTE CONTINUITY OF CARE

Some observers of Medicaid's early development suggested that the program would result in fragmented health care for the poor. In the ensuing years, EPSDT was posed as a solution to those concerns, at least with respect to the young Medicaid population. As a preventive health initiative, EPSDT was expected to link children with providers and to promote ongoing relationships between them. These relationships, in turn, were to enhance the continuity of care and rationality of service utilization. Continuity of care is important because it facilitates: (1) treatment of the whole person, (2) early detection of illnesses and handicapping conditions, and (3) appropriate health care utilization which, in turn, may reduce costs. The following practices will enhance the continuity of care.

- Use Comprehensive Providers Who Can Provide All EPSDT Services—The most effective way to assure continuity of care is to enlist providers who can conduct the entire screening examination and, all subsequent diagnosis and treatment. This approach has two major advantages: (1) EPSDT children are in contact with providers who can meet (or manage) their medical needs, and (2) comprehensive practices (such as Health Maintenance Organizations) maintain integrated medical records to which all practitioners in the clinic have access, so the actions of each practitioner can be based on the child's overall medical history, even if the primary practitioner is unavailable from time to time. Thus, this practice facilitates holistic treatment and appropriate medical utilization and reduces administering agency's case management burden.

Comprehensive providers may be multi-specialty private group practices, government supported clinics, or health maintenance organizations. Although these providers may not furnish dental care, they can make referrals to other providers or bear the risk of dental care provided under subcontract. Likewise, arrangements can be made with other providers who offer most but not all medical services, whereby they will manage the full range of care by making sure that their patients receive services from referral providers.

- Use Existing Health Care Documents To The Extent Possible—When the use of comprehensive providers is not possible, continuity of care can be fostered by: (1) developing treatment plans, (2) sharing medical information and records among providers, and (3) educating patients and generating patient profiles. Each technique is discussed briefly below:
  - Treatment Plans—Treatment plans may: (1) serve as a referral mechanism for subsequent treatment among providers, (2) transfer medical information among providers, (3) provide

practitioners comprehensive picture of planned and actual care delivered, and (4) serve as a management-by-exception tool for case managers to monitor, manage, and follow the case.

The administering agency may encourage or require providers to develop a treatment plan for each client. The content and format of the plans should be prescribed and should include conditions and illnesses found in the screen and positive diagnostics tests results, treatment required (including the procedures), duration and frequency of care. Treatment plans require the client's informed consent so that: (1) the client can be directly referred for treatment and the plan forwarded to the provider or (2) the client and plan are referred to the case manager who arranges subsequent treatment.

The feasibility of using treatment plans depends on provider attitudes, size of the eligible population, case management resources, and the agency's information system capability. Provider support is essential for implementation and may be enhanced through financial incentives, good provider relations, and training.

- Medical Information and Record Sharing—Members of the medical community commonly share medical records (when patients have given permission), although this is less likely to be the case for EPSDT patients. Clients should be encouraged to provide informed consent so that providers can share medical pertinent information with each other.
- Health Education and Patient Profiles—Fragmented care sometimes results from the clients' own actions in going willingly to more than one primary care provider. Although prior authorization can alleviate this practice, it usually is not practical. Rather, case managers should educate clients about proper utilization of health care resources. Or, case managers can review patient profiles (from the claims processing or client tracking system) to identify patients with inappropriate utilization patterns; subsequently the case manager should discuss these patterns with the client and suggest better approaches to care.

The techniques described above build on the premise that a patient's medical records and related information is the cornerstone to appropriate continuous care.

- Provide Required Care Immediately After The Screening Examination—Another problem interfering with continuity of care is that clients often do not complete necessary treatment, usually for one of these reasons: (1) fear of discovering they are seriously ill, (2) reluctance to undergo uncomfortable tests or treatment, and (3) personal difficulties and inconvenience.



In addition to health education, the following addresses these concerns:

- Screening providers should be encouraged to provide diagnostic tests and treatment during the same encounter, where possible.
- The provider or case manager should refer the client for required care possible after the screening examination.
- The length of subsequent care should be made as short as possible by setting up double appointments or by not allowing a lot of lag time between medical encounters.

Implementing the above must take into account the administering agency's prior approval process. For example, if a needed service requires prior written approval, then the provider cannot render the care during the same encounter nor immediately thereafter. In designing its policies, the administering agency must strike a balance between controlling utilization and costs (through prior authorization) and promoting continuity (through expeditious service delivery).

In sum, continuity of care can be fostered by employing comprehensive providers, by educating clients, by sharing integrated patient medical records and by expedient scheduling. Like most practices identified into this chapter, these practices are more or less practical depending on administering agency resources, the nature of the health care delivery system, and the philosophical persuasion of the State and local EPSDT program.

#### GOAL 10: PROVIDE COST-EFFECTIVE SERVICES

EPSDT implementation is increasing nationwide at the same time that Medicaid expenditures continues to rise significantly. Many States are being forced to reduce service benefits or to restrict eligibility in order to control Medicaid costs. Fiscal realities at all levels of government now dictate more than ever that EPSDT seek cost-effective methods of providing care. The following practices are directed to that end.

- Institute A Competitive Fee-For-Service System Among Providers—  
The administering agency can seek competitive bids from providers to reduce the unit cost of care or to procure services below usual and customary charges or below the prescribed fee schedule. Such a competitive process may be particularly applicable for conducting specialized components of the screening examination (e.g., development assessment or hearing and vision testing) and for prosthetic devices (e.g., eyeglasses, limb braces).

Contracts with competitively selected providers or medical supply companies should specify, at minimum, the unit cost of each service or supply, the anticipated volume of services or supplies, and quality assurance measures. Providers may or may not be guaranteed a minimum volume, but in all cases the unit price should be fixed and the risk of higher cost should be borne by the provider. This practice will

work best in States where: (1) the prevailing Medicaid rates and fees are adequate, (2) providers are in ample supply, and (3) new providers are beginning practices or a new medical supply companies are being established.

- Develop Capitation Agreement With Prepaid Health Care Providers—Several major benefits can be derived from contracting with prepaid providers: (1) for the most part prepaid providers offer comprehensive services that facilitate continuity of care, (2) the capitation arrangement places the financial risk of providing care for a particular client on the provider, and (3) contracts allow the State to anticipate costs and obligated expenditures for a relatively long period (e.g., a planning year). As Federal support for HMOs diminishes, programs may be more willing to negotiate with the EPSDT program and to meeting program standards.
- Accept Evidence of Equivalent And Ongoing Appropriate Care For Clients—Some clients receive entire or partial screening examinations (equivalent care) or establish ongoing relationships with providers (appropriate care) irrespective of EPSDT, yet, this level of care may not be taken into account in providing EPSDT care. This results in: (1) unnecessary duplicate health care services, (2) excessive Medicaid expenditures, and (3) inappropriate use of case manager's time. Since these clients already are linked to the health care delivery system serving them under EPSDT can be viewed as contrary to EPSDT's mandate to make maximum use of existing resources. Therefore, the EPSDT program should develop criteria by which it can accept evidence of equivalent or continued appropriate care in lieu of providing EPSDT services.
- Use Nonphysicians To Conduct Screening Examinations—Registered nurses, mid-level practitioners, and trained volunteers may help conduct screening examinations. This should result in cost savings and in the effective utilization of physician resources. In considering this practice the following should be taken into account: (1) reaction of the physician community, (2) availability of non-physician resources, (3) credentialing system for non-physicians, and (4) reimbursement rates.

The practices described above have potential for saving EPSDT dollars without negatively affecting the availability or quality of care. Naturally, the feasibility of each practice and its ultimate impact on cost and service delivery depends on the State environment. The existing provider network is a key factor in determining the practical application of each practice.



### CHAPTER THREE

#### DETAILED DESCRIPTION OF FOUR EFFECTIVE PRACTICES





### CHAPTER THREE

#### DETAILED DESCRIPTION OF FOUR EFFECTIVE PRACTICES





### III. DETAILED DESCRIPTION OF FOUR EFFECTIVE PRACTICES

The preceding chapter highlighted the range of effective practices identified throughout the course of this study. The purpose of this chapter is to describe, in greater depth, four effective practices to further examine their implementation potential. These four practices are: (1) fostering client responsibility for case management activities, (2) employing intensive case management activities throughout the EPSDT process, (3) mandating essential interagency linkages, and (4) developing and updating the EPSDT plan annually.

#### 1. FOSTER CLIENT RESPONSIBILITY FOR CASE MANAGEMENT ACTIVITIES

EPSDT faces the perennial challenge of encouraging clients to adhere to medical appointment schedules and treatment plans. Nonadherence is a serious problem, contributing at least to increased costs of medical care, high broken appointment rates, increased client waiting time, reduced physician productivity, and—as a cumulative result of these—weakened physician/client relationships. These problems do not plague only EPSDT. Available literature reveals that there is no relationship between patient recalcitrance and social class, age, sex, education, occupation, income, or marital status.

In deciding whether to obtain a screening examination or to follow a health plan, each individual makes rational choices by weighing the (perceived) advantages against the (perceived) disadvantages. Perversely, clients may perceive more negative than positive impact as a result of an examination or following the treatment regimen: discovering undetected diseases, physical discomfort resulting from side effects, inconvenience (missed work, transportation problems), and expense. Equally perverse, clients' experience may have demonstrated that not being examined or not following the treatment plan yields gains: avoidance of emotional stress, avoidance of physical discomfort, inconvenience and expense and, in many cases, a disease that runs its course without intervention.

Thus, client decisions not to follow treatment protocols (including scheduled appointments) may be quite rational. In any event, the client is the only one who can make these decisions. EPSDT case workers cannot control how clients behave but they can influence client behavior through three basic strategies:

- Organizational Strategies—Ensuring that services are accessible and are provided in a comprehensive fashion, and that continuity of care is achieved.
- Educational Strategies—Ensuring that each client has enough substantive knowledge to make medically informed decisions about his health care practices. This responsibility falls both on providers and, although limited health education can be provided, on EPSDT workers as a part of informing practices such as the one described here.
- Behavioral Strategies—Providing each client with information about what he/she should do in pursuing health care services and, to varying degrees, providing tools to aid patient compliance and to reinforce "appropriate" behavior.

This section discusses a practice for improving patient compliance by firmly fixing responsibility for health care with each client and family. In contrast, the next section describes a behavioral strategy in which case workers are actively involved in every aspect of treatment planning. Under this practice—foster client responsibility for case management activities—clients and families are responsible for making, changing, and keeping initial and follow-up appointments; arranging for transportation, day care, and other support services; adhering to prescribed treatment regimens; and using proper providers. Case managers or informing workers (e.g., agency staff, volunteers, client peers, etc.) are responsible for helping clients understand the need for preventive and continuous primary health care, become familiar with the EPSDT program, identify suitable providers, and learn how to develop and adhere to a health management plan.

(1) Training Required to Implement This Practice

Workers involved with this practice will function more as educators and facilitators than as monitors. To equip workers to serve in this capacity, EPSDT agencies should provide training in:

- Basics Of Preventive And Primary Child Health Care—Training should cover the major developmental stages (infancy, childhood, and adolescence) and explain the particular health risks and benefits of screening at each stage. Workers should be provided with reference materials on these subjects for their own use, as well as pamphlets to distribute to clients to supplement their discussions with clients. The latter should focus on children of different age groups and on particular disorders, so that handouts to families can be tailored to family needs.
- Listening, Counseling, And Decision Making Techniques—To perform the educator role, workers must be trained in listening techniques (so they can listen objectively to client concerns) and in counseling and decision making techniques (so they can guide clients towards taking responsibility for their own health care management and provide clients with some tools for doing so). In particular, workers should learn how to contract with clients to develop and follow a health management plan.
- Local Provider Resources—Workers must have ready access to current information about EPSDT providers: name and type of available providers (private physicians, group practices, public clinics), locations of practice in relation to transportation systems, and hours of operation (for EPSDT clinics, if applicable, and evening and weekend service, if available). One person should be responsible for verifying provider information regularly and ensuring that all workers have an adequate supply of provider information sheets (for distribution to clients).



## **(2) Implementing The Practice**

This practice begins during the intake process (or at other informing opportunities). The worker should explain that the agency will provide information assistance and financial resources (Medicaid payments), while the family (not the agency) will be responsible for all decisions that affect its health care; further, the worker should explain that he/she will collaborate with ("contract" with) the family to develop a health management plan, while responsibility for implementing the plan rests on the family. The agency staff does have the responsibility to help the family implement the plan and should not just walk away from the case and exhibit the following attitude "I told them what to do if they do not do it, its their problem."

Exhibit III-1 shows a sample health management plan. The worker should help the client complete the front of the form (one for each child) to determine the health care services needed. When possible, the client (rather than the worker) should complete the form with the worker, discussing the purpose of each question. The back of the form should be used to develop a health management plan. As the Exhibit shows, the client and worker can work together to develop the health plan. The client can then use the form to record additional action required to manage each child's health care.

When the health management plan is complete, the client should review the "contract" language on the front of the form. This confirms the client's responsibility for managing the child's health care. The worker should provide the client with a name and telephone number where help can be obtained if needed and assistance with updating the plan. Finally, the client should be reminded to bring the updated form to the next meeting with the EPSDT staff and the worker should make a copy for the agency files.

In helping clients develop health management plans, the worker should be careful to avoid assuming that all clients are the same (i.e., have the same needs and problems and, thus, can be served by a standard plan). Also, the worker should avoid the tendency to develop the plan singlehandedly; the awareness gained from participating in plan development is vital to client learning and clients must feel that the plan is their own (i.e., must "buy into" the plan) if they are expected to carry it out.

Through their counseling training, workers will have become sensitive to the reasons that clients resist planning and will become knowledgeable about ways clients inappropriately use the system. Workers also will have learned how to help clients feel at ease and enable them to derive the greatest benefit as possible from the process.

For example, clients may fear that their cash assistance is threatened unless they agree to participate in EPSDT. Clients who are motivated by fear to participate in EPSDT planning probably will not implement the health plan. In response, workers should allay client fears about income assistance, provide information so clients can assess the program on its merits, and ascertain whether client interest in the program is genuine. In each case, then, the worker must determine the likelihood that clients have sustained interest in health management and should invest counseling resources accordingly.

HEALTH MANAGEMENT PLAN

HEALTH NEEDS	ACTION REQUIRED	RESULTS OF ACTION

\*\*\*\*\*PLEASE BRING THIS PLAN TO YOUR NEXT MEETING WITH \_\_\_\_\_ \*\*\*\*\*

(REVERSE)

HEALTH MANAGEMENT NEEDS ASSESSMENT

Child: \_\_\_\_\_ Age: \_\_\_\_\_

Family Member: \_\_\_\_\_

Date Of Last Doctor Appointment Or Clinic Visit: \_\_\_\_\_

Reason For Visit: \_\_\_\_\_ EPSDT Screening Or Related Reason

Other: \_\_\_\_\_

Date Of Next Screening Required Under This Periodicity Schedule: \_\_\_\_\_

Other Known Health Problems Requiring Medical Attention Or Home Treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Regular Health Provider, If Any: \_\_\_\_\_ (NAME)

\_\_\_\_\_ (ADDRESS) \_\_\_\_\_ (TELEPHONE)

If No Regular Health Provider, See Attached List Of Available EPSDT Providers. It Lists The Name, Telephone Number, Address, And Appointment Hours For Each Provider. Each Provider Has Agreed To Serve EPSDT. Use This List In Developing The Health Management Plan On The Reverse.

I understand that EPSDT provides preventive screening examinations for the child named above and that if the screening identifies problems that require medical care, Medicaid will pay for these services. I understand the health management plan on the reverse and agree to follow that plan to the best of my ability. I also understand that I must make my own appointments and arrange for day care and transportation. Finally, I agree to update the plan if subsequent treatment is needed.

\_\_\_\_\_ (NAME) \_\_\_\_\_ (DATE)

For Questions About This Plan Or Problems In Carrying It Out, Call:

\_\_\_\_\_ (WORKER NAME) \_\_\_\_\_ At \_\_\_\_\_ (TELEPHONE)

Between \_\_\_\_\_ In The Morning And \_\_\_\_\_ In The Afternoon.

(FRONT)



## HEALTH MANAGEMENT PLAN

HEALTH NEEDS	ACTION REQUIRED	RESULTS OF ACTION
1. Dave needs screening	1. Call Dr. Jones (566-1234) on October 12 to make appointment 2. arrange for baby sitter for Patty	

Completed With Worker  
At Interview

## HEALTH MANAGEMENT PLAN

HEALTH NEEDS	ACTION REQUIRED	RESULTS OF ACTION
1. Dave needs screening	1. Call Dr. Jones (566-1234) on October 12 to make appointment 2. arrange for baby sitter for Patty	1. Appt. scheduled for November 4, 4:00. (27 Main St. Parking across street) 2. Sue Smith to sit for Patty

Completed By Client  
After The Initial  
Arrangements Are Made

## HEALTH MANAGEMENT PLAN

HEALTH NEEDS	ACTION REQUIRED	RESULTS OF ACTION
1. Dave needs screening  3. Dave needs penicillin for strep throat	1. Call Dr. Jones (566-1234) on October 12 to make appointment 2. Arrange for baby sitter for Patty 3. Pick up prescription 4. Call Dr. Jones if cough doesn't go away by November 18.	1. Appt. scheduled for November 4, 4:00. (27 Main St. Parking across street) 2. Sue Smith to sit for Patty 3. Done on November 5 4. Cough gone November 13.

Completed By The  
Client When Results  
Are Final

\*\*\*\*\*PLEASE BRING THIS PLAN TO YOUR NEXT MEETING WITH

*Jane Smith*

\*\*\*\*\*

Similarly, clients may be afraid workers will judge them harshly if they ask questions and, so, they may remain quiet throughout the process. Workers should reassure clients that they are not being judged and that, in fact, they are encouraged to ask questions.

### (3) Monitoring The System

EPSDT workers should have access to claims processing data so that client medical encounters can be tracked. This information should be used: (1) to notify clients when the next periodic screening is needed (based on whether the agreed screening was completed) and (2) to conduct intensive case management (described below) in cases at particular risk.

## 2. EMPLOY INTENSIVE CASE MANAGEMENT ACTIVITIES

The second behavioral strategy to ensure that clients adhere to the prescribed treatment protocol is to require that the case manager be actively involved in all phases of the EPSDT process. The following sections describe the role of the case manager in the major phases of the EPSDT process.

### (1) Scheduling Screening Appointments

Examination appointments should be made by the case manager immediately after the client has agreed to participate in the EPSDT program. Home visits should be conducted for clients who initially declined participation. The case manager should identify support service needs (e.g., day care, transportation), select the appropriate mode of transportation to the screening site (e.g., bus, taxi), and make all the necessary arrangements. In light of high "no-show" rates, it is advisable to over schedule for appointments by at least 25 percent to ensure that a sufficient number of clients are present for scheduled appointments.

A tickler file should be established (manual or automated) so that telephone calls can be made or a notice sent to the client one to three days prior to the scheduled appointment. The client should be reminded of the date, time, and location of the appointment, of transportation arrangements, and directions to the screening site, and to bring their Medicaid eligibility card.

### (2) Screening Appointment Follow-Up

Follow-up to determine whether a client kept a scheduled appointment can be accomplished by: (1) requesting that the screening providers (a clerk or receptionist) telephone the case manager when clients do not keep a scheduled appointment or (2) having case managers telephone the providers a day after the scheduled appointment. (The tickler file noted above will prove useful for identifying necessary telephone calls.) Subsequently, the case manager should contact the client by telephone or by mail to determine why the appointment was missed and to reschedule the screening exam. If the client cannot be contacted (after several attempts) or is unwilling to obtain a screening examination, then the client should be placed temporarily "on hold" until the next examination date (based on the periodicity schedule at which time the process begins again).



The case status (e.g., need for subsequent care or client's refusal to go for a screening examination) should be noted in the client's EPSDT record or service plan. A multi-copy turnaround referral form (which may be a combined billing invoice) may supplement the telephone conversation and provide more detailed information about the client's status.

### (3) Referral And Scheduling For Subsequent Care

In an intensive case management system, referrals for diagnosis and treatment may be made by the screening provider or by case manager. In the former cases, the screening provider's office telephones the diagnosis to the treatment provider while the client is still at the screening site to explain the need for referral and to schedule an appointment. The screening provider should also arrange for all required support services (e.g., transportation, day care, etc.) before the client leaves the office or screening site. The appropriate section of the multi-copy turnaround referral form (initiated by the case manager) should be completed by the screening provider's office and the diagnosis should be sent to the diagnosis or treatment provider and to the case manager. One copy should be given to the parent and one copy should be maintained by the screening provider in a tickler file to facilitate follow-up on the client status.

When the case manager (rather than the screening provider) takes the lead role, s/he actively arranges for diagnostic, treatment, or support services and employs the same referral mechanism. The client may be asked to meet with the case manager at the agency to review screening results and to arrange for subsequent care. Clearly, under this option there is a greater time lag between the screening and treatment and therefore, there is greater opportunity for the client's participation to falter if the case manager makes the referrals. More important, the screening provider is in the best position to make an appropriate referral.

Like screening appointments, appointments for follow-up care should be confirmed with the client and diagnosis/treatment provider either by telephone or mail, several days before the visit. This should be done by the individual who arranged for the visit (i.e., screening provider or case manager). The tickler file of referral forms will provide the necessary vehicle for initiating the confirmation of appointments.

### (4) Referral Appointment Follow-Up

Follow-up on diagnostic and treatment visits may be conducted in a fashion similar to the screening examination. The tickler file of referral forms flags cases for the individual making the referral (case manager or screening provider) to determine whether the client appeared for the scheduled appointment and to determine the overall case status. The referral source should contact the client by telephone or mail to determine the reasons for missed appointments and to reschedule a subsequent visit. A home visit should be conducted and the screening provider should contact clients who refuse an appointment after the initial contact. If the client still refused to participate, then the case should be referred to child protective services when serious conditions are involved; otherwise, the case should be held until the next required appointment.



Rescheduling and confirmation of appointments and supportive services should be conducted in the same manner as previously described, for those clients who want to continue to receive necessary treatment. Regardless of the client's status, the turnaround referral form should be completed by the diagnosis and/or treatment provider and sent initially to the individual making the referral. The appointment dates should be noted on the form for clients requiring subsequent care. The client should be contacted by the case manager or screening provider to explain the results of the diagnostic examination and the need for future care, if necessary. The cycle of arranging, confirming, and following-up on appointments should be initiated as described above, for cases requiring further care. The treatment provider will prepare the appropriate medical records and the referral form should be sent to the screening provider or case manager indicating that treatment has been completed.

### 3. MANDATE ESSENTIAL INTERAGENCY LINKAGES

State and local health and social service agencies struggle increasingly to maintain service capacity and to heighten efficiency in the face of shrinking budgets and growing demand. In even greater numbers, agencies serving children are developing interagency agreements and linkages to make the best use of finite resources, to avoid service duplication, and to create a coordinated child health and welfare community network. Through interagency linkages, each agency may better meet its own legislative and regulatory requirements as well as mutual service goals. Collaboration can expand service capacity, reduce costs, and enhance management control.

Despite growing cognizance of their value, however, such agreements remain challenging to develop and maintain. Some State EPSDT programs have established collaborative efforts, mandating linkages in these States. Mandating these linkages may be the only way to accomplish mutual efforts and to overcome the traditional barriers to their development, such as jurisdictional disputes and subtle competition. The sections below address some considerations in identifying linkage agencies and negotiating agreements, developing the content of an agreement, and implementing monitoring agreements between agencies.

#### (1) Identifying Linkage Agencies And Negotiating Agreements

Identifying potential collaborators and negotiating agreements is both a dynamic and time consuming process. Linkage agencies may be public or private, State, county, district, or municipal organizations. Examples of potential linkage agencies for EPSDT are:

- Health departments
- Department of Agriculture nutrition programs
- Welfare/social service departments
- Voluntary community agencies
- Speech and hearing programs
- Genetic disease testing facilities
- University affiliated health centers
- Job Corps sites
- Emergency Medical service units
- School systems

- Community mental health centers
- Head Start
- Title V agencies
- Medical groups
- HMOs

Generally, the Executive Director and Medical Director (of health or health related agencies) take primary responsibility for seeking collaborating agencies and negotiating agreements. Governing board members and clinical staff also can provide useful contacts in other agencies/organizations.

The initial meeting between agencies and any subsequent negotiations should always involve the Chief Administrators or Executive Directors of the potential collaborative agencies. At the initial meeting, agency heads should outline program goals, discuss mutual benefits of collaboration, and establish a fundamental working relationship. Representatives of each organization need to be sensitive to political forces and fiscal constraints that impact the other's requirements for the agreement. The prospects for developing an agreement also will be influenced by the personalities of those involved in the process, as highly incompatible personalities and politics may prevent the successful negotiation of an agreement.

If the initial meeting(s) yields a positive outlook for collaboration, each agency may then wish to nominate representatives to an advisory or working group that will draft the agreement on which further negotiations are based. Including budget office heads in this group is usually advisable; otherwise, budget personnel should be included in subsequent negotiating sessions.

## (2) Developing The Content Of Agreements

Formal agreements between agencies need not be lengthy, complex documents; rather, they are most useful when their provisions are clearly and concisely stated. A number of standard provisions facilitate implementation and avoid misunderstandings throughout the term of the agreement. These provisions should describe:

- The purpose and general scope of the agreement, including citation of applicable regulations or statutes mandating cooperation
- The term of the agreement and provisions for termination by either agency
- Measurable objectives and goals, such as service needs of the target population, mutual service goals, standards of care, and service protocols
- Areas of collaboration, e.g., health education, vision screening, outreach, informing, referral, confidentiality



- Responsibilities of each agency for:
  - Staffing
  - Facilities
  - Administration
  - Equipment
  - Referrals
  - Documentation
  - Information sharing
  - Funding
- The implementation plan, specifying time frames and training needs, technical assistance, and informational materials to be provided by each agency
- A monitoring plan, including indicators of effectiveness (or the date by which they will be developed), documentation required (this should be drawn from current data), provisions for periodic reviews and site visits, and a schedule for reviewing the agreement
- Financing, reimbursement and payment arrangements, in which reimbursable services, payment mechanisms (fee for service, prospective funds transfer based on anticipated volume, capitation, actual cost, etc.) and billing mechanisms are defined

### (3) Implementing And Monitoring Agreements

After executing an agreement, agencies often experience difficulty in implementing, monitoring, and maintaining the linkage. Among the chief reasons for these problems are:

- Inadequately addressed philosophical differences
- Unclear statements of responsibilities
- Unanticipated or underestimated fiscal constraints
- Changes in key personnel

In addition to developing the agreement to include the provisions described above, agencies can improve the chances for a smoother, more long-lasting collaboration by:

- Maintaining the liaison established during the negotiation process
- Training staff in the provisions of the agreement, e.g., documentation, tasks, referral patterns
- Conducting regular meetings to discuss and resolve implementation and monitoring problems



- Conducting joint site visits to ensure that each agency's interests are represented in performance assessments
- Tying the monitoring plan to the information system and joint site visits

Finally, the monitoring plan should include periodic review and renegotiation of the agreement to ensure that it reflects changes in responsibilities and policies, and other changes based on experience.

#### 4. REQUIRE EACH COUNTY OR LOCAL OFFICE TO SUBMIT AN ANNUAL PLAN TO SERVE AS A BASIS FOR DEVELOPING A STATEWIDE EPSDT PLAN

The EPSDT program is a system which requires the careful melding of administrative, financial, and service delivery procedures to be responsive to State and community needs. Like most systems, each component of the program when integrated as a whole produces greater benefits than the individual components when added together. In designing the management and health care component of EPSDT, the administering agency must consider variables including the client population, provider network, agency structure, financial resources, community environment, interagency linkages, and health care protocols. The multiplicity of these variables requires a systematic approach in developing the appropriate EPSDT program to effectively provide health care to eligible children within the State and within a particular locality.

Instituting a planning process requires each county to submit an annual plan to serve as a basis for developing a statewide EPSDT plan which will provide the necessary systematic approach for designing an EPSDT program. As previously indicated, comprehensive program plans and the processes required to create them offer several benefits; they: (1) promote a rational allocation of resources to meet priority needs and to reflect operational realities, (2) create a vested interest in EPSDT by participating in the planning process, (3) serve as a basis for monitoring program progress, and (4) provide a vehicle for promoting EPSDT and articulating its mission. In essence, the planning process will foster the maximum utility of limited resources and promote the maximum impact of services on clients. The following provides a description of the nature and scope of a suggested planning process for EPSDT.

##### (1) Planning Cycle

Planning is a cyclical and continuous process whereby each element of the cycle is tied together. The planning process should begin with the development of a policy which contains: (1) an overall assessment of the key issues affecting EPSDT operations, and (2) a description of the overall direction or basic goals set by policy makers for the forthcoming year. This plan should be promulgated by the head of the Single State Agency responsible for EPSDT. Its purpose is to provide guidance and direction to the State EPSDT unit and to counties or local offices for developing the specific EPSDT plan. This will help ensure that EPSDT plans are integrated with overall agency goals and that the policy maker supports EPSDT efforts.

The second step in the process is to conduct a needs assessment to determine the characteristics and health care needs of the client population. This needs assessment will enable the State and county to precisely identify those in greatest need and to focus their resources accordingly. A part of the needs assessment can be conducted by: (1) reviewing agency statistics, (2) conducting a survey of the client population, and (3) interviewing case managers or outreach workers. In conducting the needs assessment, it is important to confirm the magnitude and geographic location of the target population. The target population for the EPSDT program may be divided into the following four subgroups: (1) perinatal, (2) preschool, (3) school age, and (4) adolescents.

The third phase of the planning process should be to conduct a resource assessment. The purpose of the resource assessment is to identify the resources available to serve those in need. In conducting a resource assessment for EPSDT, it is important to consider the provider network, internal agency staff, available agency financial resources, resources of other allied agencies, and volunteers.

The fourth phase is to develop the actual plan. The purpose of the plan is to provide an overall framework for the actual program in the forthcoming year. The plan should provide a comprehensive picture of the entire EPSDT program including the administrative aspects, case management process, screening, diagnosis, and treatment process, and financial resources required to administer the EPSDT program and to render health care services.

The fifth phase of the cycle is the implementation of the plan. This entails making all the changes with regards to staffing patterns, provider linkages, interagency linkages and administrative processes.

The sixth phase of the planning cycle is to monitor actual performance against planned performance and to make any necessary adjustment in actual program operations as needed. The agency's management information system should be designed to provide the required monitoring data, monthly.

The final phase of the process is to conduct an evaluation of the entire year with regard to overall program performance from three perspectives: (1) service delivery and client impact, (2) financial, and (3) management. The result of this evaluation will provide the foundation for the first phase of the next year's planning process i.e., policy development.

## **(2) Contents Of The Actual Plan**

The plan document should provide a blueprint for enhancing a program's operations and/or promote a more rational allocation of external and internal resources. The exact format of the plan should be designed to meet each State's operational needs. What is important is that the format for the county and/or local office plans are consistent statewide and that all components of the EPSDT program are covered by the plan. It is suggested that the plan be divided into the following components:



- Performance Appraisal—Each county or local office should draft a self-appraisal of their accomplishments for the preceding year based on the goals and objectives presented in the prior year's plans. This performance appraisal should describe variances between what was planned versus what was actually accomplished and reasons for the variance. This section of the plan provides several advantages: (1) it promotes program accountability, (2) it fosters program self-monitoring and appraisal, (3) it provides a formal mechanism for a program to identify their accomplishments, (4) it facilitates county and ultimately, State monitoring activities, and most important, (5) it provides a basis for establishing next year's program goals and objectives, i.e., what was not accomplished last year may be carried over into the following year or what was achieved last year may be an initial step to fulfillment of a larger, more ambitious undertaking.
- Needs And Resources Assessment—The second component of the plan should include a needs and resources assessment conducted by the county or local office. The assessment should highlight the specific needs of the sub-population groups discussed previously by catchment area and the nature and mix of the provider and agency resources that will be used to fill the specific needs. Additionally, the needs and resource assessment should highlight particular gaps in service delivery and how the agency plans to fill those gaps.
- Description Of EPSDT Operations—This component of the plan should provide an overview of the overall operations of the EPSDT program from two perspectives. First, a description of the case management system by the county and/or local office should be discussed in terms of the process flow, staffing, and information system. Second, this component should also describe the provider mix and protocols that will be used for conducting screening examinations as well as for providing the necessary diagnostic and treatment health care services.
- Action Plan—The fourth component of the plan should contain the counties or local office direction or thrust of their efforts (what they want to accomplish) for the forthcoming years, for case management, screening, diagnosis, and treatment, and program administration. The first step in identifying program direction is to delineate goals for each of the four program areas. A goal is an overall statement of the intent or the expected outcome of the activities that will be undertaken during the plan year. For the most part, the goals should be similar for each county and should not vary significantly from year to year.

For each goal, the program should identify specific objectives. These objectives should reflect either an area in which the county is experiencing some difficulty or an area in which the county desires improvement. Objectives will vary among



counties and will also vary from year to year. Objectives should be measurable in terms of what is to be achieved and in what time frame.

Action strategies should identify the proposed approach or method that will be used to achieve the goals and objectives. Specifically, action strategies should contain a statement of what will be done, how it will be done, when, and by whom.

The program also should indicate how the action plan will be evaluated, i.e., criteria for measuring performance, evaluative techniques, and evaluation strategies.

- Budget—A detailed line item budget should be developed for each of the major program areas for EPSDT (e.g., case management, screening, diagnosis, and treatment, and administration). The budget should contain administrative as well as vendor payment costs. This component of the plan may be designed as standardized tables and does not require extensive narrative descriptions.

The same format as described above may be used by the State to develop the annual statewide EPSDT plan.

### (3) Suggested Planning Process

The process should begin with the State agency developing planning guidelines for county and local office EPSDT plans. These guidelines should: (1) identify the State's assessment of key issues, overall direction, and priorities for the forthcoming year, (2) provide the specific content and format for preparing the county or local office plans, and (3) provide suggestions to the county regarding the plan development process. These guidelines should be distributed 90 days prior to the submission date.

The counties should begin the planning process by reviewing last year's performance—accomplishments as well as any problems encountered. Linkage agencies, providers, and consumers should be brought into the planning process at the earliest possible opportunity. An assessment of the needs and resources and a preliminary draft of the action plan should be devised. This should be reviewed with agency policy makers and any standing advisory council as described in Chapter Two. The plan should then be open to public comment either through hearings or available for review at key locations. Appropriate modifications should be made of the plan as a result of the review process and the final plan approved by the county agency or director of the local office.

The State agency should initially review the plans for completeness and to ensure they are consistent with their guidelines. State staff should contact the programs or local offices by telephone to clarify any problem statements, if necessary, and to obtain any additional information. After the initial review of the county plans is complete, State staff should analyze the

plans to determine similarities and unique aspects among county and local office plans. This analysis should provide a basis for developing an annual statewide EPSDT plan.

The development of the statewide annual EPSDT plan should adhere to a similar process described above for the counties. Collaborating agencies and representatives of a standing advisory committee should provide input into the State planning process as soon as possible and drafts of the needs and resource assessments as well as the action plans should be reviewed by those involved with the EPSDT program. The plan should be well publicized and then be open to public comment before it is finalized. This process will ensure that the State plan reflects the operational realities at the delivery level as well as to provide a mechanism to tap additional expertise and support of all those affected by the EPSDT program.





APPENDIX A  
STATE PROFILE DIRECTORY



STATE: Alabama

REGION: IV

STATE EPSDT COORDINATOR:

NAME: Mrs. Mary Browder

TITLE:

AGENCY: Medical Services Administration

ADDRESS: 250 Fairland Drive  
Montgomery, Alabama 36130

PHONE: 205-277-2710, ext. 341

1. AGENCY ADMINISTERING EPSDT IS: Health
2. PROGRAM IS: State Supervised/County Administered
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 30,000
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

☒ AFDC intake interviews

☐ Other outreach activities (specify):

☐ Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	15%	100%
Health Department	85%	
Comprehensive Providers		
Other (specify)		



6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Child health and Medical Services Administration contacts providers to enroll as XIX providers. Providers must express interest, then State makes personal contact.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*No seperate medical advisory group.*

*State Pediatric Association initially gave advise on how to set up program.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

     Automated?  
  X   Manual?

     Both?  
     Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Changes pending in future. No firm dates have been set.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*In conjunction with State Public Health Department, agency tries to have at least one workshop per year. Conducts informal contacts through site visits every 3 months with providers.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design  
Outreach/Informing  
Case Management/MIS

Services Delivery  
(Screening, Diagnosis,  
and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.

10. (Continuation Sheet for Description of Effective Practices).

1. *County Health Departments are a strong point in State.  
They are doing much of the screening in the counties.*
2. *Problem with referrals - Many areas, particularly  
rural, do not accept Medicaid.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

- *Some counties have volunteers which will do transportation, mostly rural.*
- *Informal agreements with Head Start at local levels.*

B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*CCS and PHS agreements.*



STATE: *Alaska*

REGION: *X*

STATE EPSDT COORDINATOR:

NAME: *Ms. Val Lennon*

TITLE:

AGENCY: *Deaprtment of Health and Social Services*

ADDRESS: *Pouch H-06E*

*Juneau, Alaska 99811*

PHONE: *907-465-3388*

1. AGENCY ADMINISTERING EPSDT IS: *Umbrella*

2. PROGRAM IS: *State Administered*

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *10,600*

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

*X* AFDC intake interviews

       Other outreach activities (specify):

*X* Other: *Public Health Nurses*

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	<i>10%</i>	<i>96%</i>
Health Department	<i>90%</i>	
Comprehensive Providers		
Other (specify) <i>Public Health Nurses (under standing orders)</i>		<i>4%</i>

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Division of Public Assistance handles recruitment. All licensed physicians are accepted based on application, not differentiated from Medicaid.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Medical care subcommittee makes recommendations for screens, etc. AAP used as basis for the subcommittee. Subcommittee meets 3-4 times a year.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>X</u>	Automated?	<u>          </u>	Both?
<u>X</u>	Manual? (mostly)	<u>          </u>	Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Mid 1982, MMIS will be up and running. EPSDT will be part of the system.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Annual training for all PH nurses: outreach, screening, follow-up. Includes new techniques and refreshers.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.

10. (Continuation Sheet for Description of Effective Practices).

*Using PH nurses for outreach all the way through treatment  
and follow-up. Monitored closely.*



## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*Head Start uses same screening form.*

*Indian Health Service does few screens but a great deal of follow-up.*

*PCIS (Patient Care Information System) provides medical history of all Alaska Natives. Fifty-five (55) percent of AFDC are Eskimo or Aleut.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*There are contracts with a few dentists and specialists to provide services on a once-only basis when public health nurses are overloaded and Indian Health Service cannot provide the specialty.*

STATE: Arkansas

REGION: VI

STATE EPSDT COORDINATOR:

NAME: Ms. Bernice Gibson  
TITLE: Division of Social Services  
AGENCY: Arkansas Department of Human Services  
ADDRESS: P. O. Box 1437  
Little Rock, Arkansas 72203  
PHONE: 501-371-1473

1. AGENCY ADMINISTERING EPSDT IS: *Social Service/Welfare*

2. PROGRAM IS: *State Administered*

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *80,000*

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

☒ AFDC intake interviews

☒ Other outreach activities (specify): *Health Department conducts all outreach and case management functions, offer referral from intake.*

☒ Other: *Nonparticipating families are reformed, through semi-annual reevaluations. An annual mailing is also sent.*

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians		100%
Health Department	99%	
Comprehensive Providers		
Other (specify)		

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*The Medicaid provider unit furnishes the providers' numbers and maintains the provider roles. A recent effort to contact all providers to recruit for screening services resulted in a disappointing response of only about 100 and very few assessments. Private physicians appear to resist efforts by the Health Department to assure completion of treatment services and object to the paper work.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*EPSDT makes effective use of the Medicaid Medical Advisory Committee.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u> Automated?	<u>      </u> Both?
<u>  X  </u> Manual?	<u>      </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Considering changing case management responsibility from Health Department to in-house social service staff, because social workers appear to have greater clout with eligibles.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Staff development unit in Medical Services has responsibility for EPSDT as part of Medicaid.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*See discussion of contract with Health Department under 11.B.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*Crippled Children's Services (CCS) are part of the Division of Social Services; and as a result, EPSDT works closely with CCS.*

*An agreement with Head Start provides for referring Medicaid eligible children to EPSDT.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*A contract with the Health Department provides for a flat fee payment of \$51.14 for each completed assessment. Referrals are made from intake, then the Health Department makes an offer of EPSDT services, provides assistance with scheduling and transportation, arranges for referrals including transportation, and completes direct dental referrals.*

STATE: California

REGION: IX

STATE EPSDT COORDINATOR:

NAME: Siegfried A. Centerwall, M.D.  
TITLE: Chief, CHDP Branch  
AGENCY: Department of Health Services  
ADDRESS: 714 P Street, Room 1792  
Sacramento, California 95814  
PHONE: 916-322-4780  
FTS 8-552-8041

1. AGENCY ADMINISTERING EPSDT IS: Health
2. PROGRAM IS: State Supervised/County Administered
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 1,319,467
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  X   AFDC intake interviews

  X   Other outreach activities (specify): In school on entry into kindergarten and first grade.

  X   Other: In Head Start and State Preschool programs.

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	36.9%	
Health Department	21.8%	Data
Comprehensive Providers	.4%	Unavailable
Other (specify)Community Hospitals-		
Outpatient/Organized Outpatient Clinics		
OEO Clinics		
Non-profit Organizations		
Day Care	14.3%	
Schools	6.9%	
Other	3.0%	
Unclassified	16.7%	



6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*By County CHDP programs. They certify, train, and support the providers in their county. The State program occasionally sends out a letter with information about the program to private MDs and invites their participation.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Private providers or State Child Health (Advisory) Board liaison persons with American Academy of Pediatrics and California Medical Association. Members of the Child Health Initiative Task Force and California Dental Association.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u> Automated?	<u>  X  </u> Both? (but mostly manual)
<u>      </u> Manual?	<u>      </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*An automated system is being designed through a contract by HCFA.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Each county program is required to do training for local Health Department and Welfare Department staff and assist the local schools with outreach and education. The State program holds workshops for health and welfare staff at the local level about program planning.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.

## 10. (Continuation Sheet for Description of Effective Practices).

### Program Management

1. Slide show with audio to recruit prospective providers (produced by Claire Mueller, Orange County Program, California).
2. Periodicity schedule defined in terms of the period of time since the previous screen, i.e., the screen after the 2-year assessment is "due" in 1 year, the screen after the 4-5 year assessment is "due" in 2 years. This simplifies periodicity informing and is in accord with actual practice.
3. Appropriate health education component of each health assessment (screen) is being defined by age group. Guidelines for guidance in parenting and car safety are being developed.
4. Fee schedule provides an increment for providers who include the child in a comprehensive care program, providing diagnosis and treatment, follow-up on referrals and periodic screens.
5. Reports from automated data based on screens shows provider activity and whether complete screens are being done.

### Outreach and Informing

1. Funding of health educators in the county programs. They work with welfare departments, schools and providers, and plan education and outreach through the media.
2. Outreach by the schools to children entering kindergarten and first grade.
3. Education of children and teachers in kindergarten and first grade about the program (health check-ups).

### Case Management/MIS

1. Uniform form for all California programs to document referral for screen, screens, referral for diagnosis and treatment, and diagnosis and treatment.
2. Computerized claims payment and data collection system.

### Screening, Diagnosis and Treatment

1. Schools are screening providers.
2. Head Start and Preschool programs are screening providers.
3. Agreement with CCS for follow-up to diagnosis and treatment.

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*Interagency agreement with State Department of Social Services for informing and referral by local welfare departments.*

*Interagency agreement with Head Start for cooperation in providing services to Head Start children.*

*Interprogrammatic agreement with Title V programs for cooperation in referral and follow-up of Title XIX children.*

*Working on interagency agreement with State Department of Education for (1) coordination in the provision of services to handicapped children and (2) provision of EPSDT outreach and follow-up services in schools.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*None*



STATE: Colorado

REGION: VIII

STATE EPSDT COORDINATOR:

NAME: Ms. Phyllis Payne, R.N.

TITLE: EPSDT Coordinator

AGENCY: Division of Medical Assistance

ADDRESS: 1575 Sherman Street

Denver, Colorado 80212

PHONE: 303-866-3255

1. AGENCY ADMINISTERING EPSDT IS: Social Service/Welfare

2. PROGRAM IS: State Administered

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 54,477

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

☒ AFDC intake interviews

☒ Other outreach activities (specify): At intake when clients apply for assistance.

☐ Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	50%	100%
Health Department	50%	
Comprehensive Providers		
Other (specify)		

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Through fiscal agent, provider relations, and much through EPSDT Outreach workers and nurse supervisors at local health department.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Pediatrician M.D. American Dental Association - their input was requested for validation of periodicity schedule, billing forms, developmental assessment, etc.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u> Automated?	<u>      </u> Both?
<u>  X  </u> Manual?	<u>      </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*APD mailed to OMB for approval 01/26/82. Projected implementation of automated case management system is August 1, 1982.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Directions are given to health EPSDT program director and training officers, who in turn train EPSDT outreach workers through regional workshops.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.

10. (Continuation Sheet for Description of Effective Practices).

Colorado was accomplishing the screenings, this was verified by percentage of recipients screened - from 1972 to 1978; but because we did not have the regional documentation as was specified via regulations, Colorado Department of Social Services contracted with the Department of Health to do the outreach and case management. Also the EPSDT outreach workers who work directly with Medicaid eligible families find out problems encountered: (1) as receiving bills for Medicaid services received, (2) can answer questions as to what services are Medicaid benefits, and (3) where services can be obtained. Barriers: (1) Colorado does not have enough Medicaid providers for specialty areas, particular optometrists and opticians because of inadequate reimbursement rate and (2) lack of OBGYN physicians in several areas.



## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*Rural local health departments for EPSDT screenings*  
*Head Start*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*Colorado Department of Health to do outreach and case management*  
*Handicapped Children's Program*  
*Mesa HMO*  
*San Luis Valley HMO*

STATE: Connecticut

REGION: I

STATE EPSDT COORDINATOR:

NAME: Ms. Elaine Pegalo

TITLE:

AGENCY: Department of Income Maintenance

ADDRESS: 110 Bartholomew Avenue

Hartford, Connecticut 06106

PHONE: 203-566-2772

FTS 8-641-2772

1. AGENCY ADMINISTERING EPSDT IS: Social Service/Welfare

2. PROGRAM IS: State Administered

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 110,000

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  X   AFDC intake interviews

       Other outreach activities (specify):

  X   Other: Periodic redetermination interviews

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	53%	No reliable data at present
Health Department	9%	
Comprehensive Providers	13%	
Other (specify): V.N.A. school system and school based clinics	23% 2%	

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Interested EPSDT providers are visited in their medical settings and given a detailed explanation of the program.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*An EPSDT Advisory Committee was formed and has held periodic meetings. Representatives of the State Dental Society, AAP, Public Health Departments and State Hospital Association serve on this committee.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u>	Automated?	<u>  X  </u>	Both?
<u>      </u>	Manual?	<u>      </u>	Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Yes, depending upon the number of referrals from revised billing system, we plan to change district office tracking procedures. Since the system is still very new and projected data has still not been obtained, no definitive plans have been made.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Quarterly full staff training sessions are given to improve staff outreach communication skills, and health education knowledge.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

- a) Connecticut's EPSDT program has been expanded to include women pregnant with their first child who are applying for assistance. This group is composed mostly of young pregnant women who range from 14 to 19 years of age. These pregnant women are interviewed at the time of AFDC application by EPSDT health workers in the District Offices. During the interviews the women are counseled in the importance of regular medical care during their pregnancy and the importance of periodic check-ups of their newborns. If needed, they are referred to appropriate support services such as WIC and young parent's programs.
- b) The State of Connecticut has also spent much time and effort in implementing a computerized periodicity system based on bills processed and age of child due for rescreening. Approximately 6,000 rescreening notices and 2,000 dental check-up notices are sent out each month. The value of sending out these periodicity notices is undeterminable as there is little feedback from families who receive these notices and from the medical community who may not have a child make an appointment for rescreening as a result of the notices.

## 11. COLLABORATIVE EFFORTS/CONTRACTS

A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

1) *Agreement with Department of Children and Youth Services to inform children in AFDC-FC categories.*

2) *Agreement planned with MCH Section of Health Services to share information and to coordinate services to better serve eligibles.*

3) *EPSDT Central Office is serving on Statewide Interagency Early Intervention Committee. The goal of this committee is to coordinate available health and education services to children aged 0-6 especially in light of P.L. 94-126*

B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*All medical providers of EPSDT Screening Services sign a contract with the Department of Income Maintenance to perform screening services for fees indicated and to make referrals for further diagnosis and treatment when appropriate.*

STATE: Delaware

REGION: III

STATE EPSDT COORDINATOR:

NAME: Mrs. Thelma Mayer  
TITLE: Division of Social Services  
AGENCY: State Department of Health and Social Services  
ADDRESS: P.O. Box 309  
Wilmington, Delaware 19899      PHONE: 302-421-6137

1. AGENCY ADMINISTERING EPSDT IS: Umbrella
2. PROGRAM IS: State Administered
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 25,000
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

\_\_\_\_\_ AFDC intake interviews

\_\_\_\_\_ Other outreach activities (specify):

  X   Other: Division of State Service Centers does it immediately  
after the AFDC intake interview.

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians		(Done by physicians
Health Department	100%	and health department:
Comprehensive Providers		no breakdown available.
Other (specify)		Dental: 100% by Division of Public Health.)

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Periodic efforts made.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Division of Public Health is primary contributor when new regulations are issued.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>  X  </u>	Automated?	<u>      </u>	Both?
<u>      </u>	Manual?	<u>      </u>	Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*None at present.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

## 11. COLLABORATIVE EFFORTS/CONTRACTS

A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

1) *Dental Services - Provided by Division of Public Health.*

2) *Dental Services - One public school and one community medical clinic.*

3) *Vocational Rehabilitation - Referral services.*

4) *Children's Bureau of Delaware, Inc. - Screening for children in their foster homes.*

B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*Dental - One contract with Wilmington Medical Center - Delaware Division.*

STATE: Washington, D.C.

REGION: III

STATE EPSDT COORDINATOR:

NAME: Ms. Lois Branic  
TITLE: Department of Human Services  
AGENCY: Office of Health Care Financing  
ADDRESS: 614 H Street, N.W., Room 708  
Washington, D.C. 20001

PHONE: 202-727-0751

1. AGENCY ADMINISTERING EPSDT IS: Umbrella
2. PROGRAM IS: State Administered
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 82,500
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

☒ AFDC intake interviews

☒ Other outreach activities (specify): EPSDT contractor  
informs eligibles also.

☐ Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	25%	25%
Health Department	75%	75%
Comprehensive Providers		
Other (specify)		

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Contractor is to expand and increase availability of EPSDT services.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Done through D.C. Medical Care Advisory Committee, which meets monthly (except for July and August).*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u> Automated?	<u>      </u> Both?
<u>  X  </u> Manual?	<u>      </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Contractor is in process of setting up automated system linked to MMIS.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*The contractor, Philadelphia Health Management Corporation (PHMC), provides training.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*Contractor is just beginning work in D.C. It is too early to offer any statements regarding this area.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*The contractor presently is developing linkages with day care centers and schools.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*PHMC Contract*

*Scope of services: Establish and operate EPSDT program - specifically arranging, informing, screening and any necessary following services for a minimum of 25,000 new and existing Medicaid-eligible children under 21.*

STATE: Florida

REGION: IV

STATE EPSDT COORDINATOR:

NAME: Ms. Sandy Axelson  
TITLE: EPSDT Coordinator  
AGENCY: Department of Health and Rehabilitation Services  
ADDRESS: Medicaid Office  
1323 Winewood Boulevard  
Tallahassee, Florida 32301  
PHONE: 904-488-9347

1. AGENCY ADMINISTERING EPSDT IS: Umbrella
2. PROGRAM IS: State Administered
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 260,000
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

X AFDC intake interviews

X Other outreach activities (specify): Monthly lists of EPSDT eligibles - generated from Assistance Payments Records and SDX. District outreach staff contact clients by field visit, letter or telephone.

\_\_\_\_\_ Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	5%	70%
Health Department	90%	25%
Comprehensive Providers	5%	5%
Other (specify)		

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

- 1) *Through articles in professional journals and newsletters.*
- 2) *District provider recruitment by contacting area providers.*
- 3) *Information exchange at professional meetings.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Florida has a Medicaid Advisory Council with representation from all medical and dental associations. The Council meets quarterly to discuss policy issues. All policy development is reviewed by representatives of the provider community through organizational meetings. The EPSDT program utilizes a committee from the Florida Pediatric Society. The committee is titled "EPSDT Technical Assistance Committee." The EPSDT Coordinator also attends meetings of the Executive Committee of the Florida Pediatric Society.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>X</u>	Automated? (partially)	_____	Both?
<u>X</u>	Manual? (Performed by direct	_____	Linked to MMIS?
	<i>service workers in the district/counties.</i>		

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Currently linking with MMIS on an ongoing basis.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Case management and client tracking procedures to be revised by July 1981. Statewide training of EPSDT staff (case managers) in June 1981. EPSDT units around State to be established by July 1981. Each district (11 HRS districts) will establish an EPSDT coordinator to supervise EPSDT functions.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

The Florida EPSDT program has an EPSDT Coordinating Committee made up of representatives of the various HRS programs involved in implementation of the program. The Committee includes a pediatric advisor, district staff and others appropriate to the issues discussed. The Committee provides input to program policy and procedure. The current activities of the Committee include development of an EPSDT plan and a coordinated monitoring plan which outlines the various program responsibilities.

Florida will have specialized EPSDT staff (EPSDT case managers) with responsibility for outreach and case management beginning July 1, 1981. (Payments staff handle the informing.) These staff are located in social service units and funded by Title XIX. The staff are organized into EPSDT units where ever the geographics of the district permit. This staffing arrangement will reduce fragmentation of program. EPSDT Coordinators responsible for training, monitoring and provider recruitment will be established in each district.

We have established a pilot project with local HUD agencies and the County Primary Health Clinic to perform outreach and case management activities. The health clinic will provide a mobile screening site at the HUD project and complete screenings for eligible children visiting there.

We are also establishing agreements with the local county health departments for case management and client tracking. The Health Department funds the 25% GR for case managers with the 75% FFP.

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.
- 1) *Agreement with State District Health Program Office, Children's Medical Services, Economic Services, and Children, Youth and Family offices as all are involved in EPSDT.*
  - 2) *Pilot Projects:*
    - a) *Agreement between Medicaid, Fort Lauderdale Housing Project and Primary Health Care of Broward County.*
    - b) *Agreement between county health departments and District Medicaid offices.*
  - 3) *Planned:*
    - a) *Schools*
    - b) *Head Start*
    - c) *Housing Authorities statewide for outreach*
    - d) *Local volunteer services agencies*
- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.
- 1) *Contract with Broward Correctional Institute to make eyeglasses (volume purchasing).*
  - 2) *Contract with hearing aid manufacturers for hearing aids used by dispensers statewide (30% savings from previous years).*

STATE: Georgia

REGION: IV

STATE EPSDT COORDINATOR:

NAME: Ms. Edwlyn Heyward  
TITLE: Division of Benefit Payments  
AGENCY: Department of Medical Assistance  
ADDRESS: 1010 West Peachtree  
Atlanta, Georgia 30309  
PHONE: 404-894-4955

1. AGENCY ADMINISTERING EPSDT IS: *Umbrella*
2. PROGRAM IS: *State Supervised/County Administered*
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *205,500*
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  X   AFDC intake interviews

       Other outreach activities (specify):

       Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	25%	100%
Health Department	73%	
Comprehensive Providers		
Other (specify) <i>Rural Health Clinics</i>	2%	

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Provider relations officer does training and recruitment.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Interdepartmental committee.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

  X   Automated?  
      Manual?

      Both?  
  X   Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*No changes planned unless regulations change.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Department of Human Resources usually trains individuals to do EPSDT. Normally, Department does provider relations and training to upgrade quality of staff.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design  
Outreach/Informing  
Case Management/MIS

Services Delivery  
(Screening, Diagnosis,  
and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*Sophisticated system.*

11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*There are working relationships between Department of Medical Assistance and various program divisions. Human Services Divisions (County Family and Children Services) do service delivery.*

*Local health departments and provider physicians work closely with the DMA.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*Title V and XIX - underway*

*CCS - negotiating*

*HUD - negotiating*

*Division has a problem currently with budget cuts.*

STATE: *Hawaii*

REGION: *IX*

STATE EPSDT COORDINATOR:

NAME: *Ms. Loretta Fujiwara*

TITLE: *EPSDT Coordinator*

AGENCY: *Department of Social Services and Housing*

ADDRESS: *P. O. Box 339*

*Honolulu, Hawaii 96809*

PHONE: *808-548-8429*

1. AGENCY ADMINISTERING EPSDT IS: *Social Service/Welfare*

2. PROGRAM IS: *State Administered*

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *45,874*

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  *X*   AFDC intake interviews

  *X*   Other outreach activities (specify): *contract with Department of Health, outreach worker teams, and some provider informing.*

       Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	25%	100%
Health Department Screening Team	75%	
Comprehensive Providers		
Other (specify)		

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Original outreach was undertaken by formal letter. October 1, 1979 signaled the beginning of a new recruitment effort. Reimbursement rate was raised. Only full screens would be paid at the new rate. Annual flyers sent out and a personal interview with all interested providers is taken. Difficulty with group providers concerning billings.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Met with Hawaii Dental Association - fantastic cooperation. Hawaii Pediatric Association had no input, although invited. Children's Hospital, School of Public Health, Medical School, Family Practice, Health Department all had input.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u> Automated?	<u>  X  </u> Both?
<u>      </u> Manual?	<u>      </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*RFP for MMIS incorporation is being held back pending the new regulation.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Continuous program of training is conducted for all new outreach workers. Staff development program may include EPSDT in the future.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*Clients have found the program to be too repetitious. Declinations have increased. This is in a great extent due to clients using continuing care providers.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*Good working relationship with a program administered by the Department of Education. This is the second part of Head Start, Follow Through. For those eligible for Medicaid, screening and followup is completed under this program and EPSDT pays for the screen and treatment.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.
1. *Screening contract with the Health Department, EPSDT pays for the screens.*
  2. *Administrative contract for outreach with the Health Department.*
  3. *A few contracts with outpatient clinics and community based centers to provide screens.*

STATE: *Idaho*

REGION: *X*

STATE EPSDT COORDINATOR:

NAME: *Mr. William Overton*

TITLE: *Health-Check Coordinator, Medical Assistance Section*

AGENCY: *Department of Health and Welfare*

ADDRESS: *State House*

*Boise, Idaho 83720*

PHONE: *208-384-4144*

1. AGENCY ADMINISTERING EPSDT IS: *Social Service/Welfare*

2. PROGRAM IS: *State Administered/County Supervised*

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *16,500*

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  *X*   AFDC intake interviews

       Other outreach activities (specify):

       Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	<i>50%</i>	<i>100%</i>
Health Department	<i>50%</i>	
Comprehensive Providers		
Other (specify)		

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Professional liaison with physicians and practicing registered nurses.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Advisory body; interest groups.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>  X  </u>	Automated?	<u>      </u>	Both?
<u>      </u>	Manual?	<u>  X  </u>	Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Yes, by January 1982*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Twice yearly State conferences. Visits by EPSDT Coordinator to county sites for training caseworkers 2-4 times yearly.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*Training program is characterized by big benefits and low costs.*

*Manual is very flexible and allows for regulation changes.*

*Coordinator has indepth experience in multi-State delivery systems.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*EPSDT - MCH and WIC, respectively. These programs carry out specific aspects of the program. Some MCH clinics do some of the screening.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*Titles V and XIX interagency agreements recently negotiated and signed. This was based on current economic and administrative realities.*

STATE: Illinois

REGION: V

STATE EPSDT COORDINATOR: (Outreach, case management): (medical services):

NAME:	Mr. Charles A. Pfotenhauer	Mr. Wesley J. Duiker
TITLE:	Medichek Program	Medichek Program Supervisor
AGENCY:	Illinois Department of Public Aid	Illinois Department of Public Aid
ADDRESS:	528 S. 5th Street Springfield, Illinois 62762	931 E. Washington Street Springfield, Illinois 62703
		PHONE: 217-785-0490 FTS 959-0490

1. AGENCY ADMINISTERING EPSDT IS: Social Services/Welfare

2. PROGRAM IS: State Administered

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 561,793

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

☒ AFDC intake interviews- for new applicants

☒ Other outreach activities (specify): All reactivated and new cases.  
Also postcards and brochures are mailed or handed out.

☐ Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	75%	75%
Health Department	*25%	
Comprehensive Providers		25%
Other (specify)		

\*Combined - Health Department and Comprehensive Providers

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Medicaid Division has full responsibility. Staff in provider services of the Medical Division also performs this task.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*AAP, American Dental Society, State Medical Society, and State Medical Advisory Committee had input into the EPSDT program design.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u>	Automated?	<u>  X  </u>	Both?
<u>      </u>	Manual?	<u>      </u>	Linked to MMIS?

*MMIS is not totally operational*

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*No. Now moving into MMIS.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*All new staff and those newly promoted are trained by manual procedures. Providers receive training through workshops, telephone conversations, letters, etc.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*Private physicians refer patients to the system with or without the patients' knowledge, following screenings on a billing form. All Title XIX providers are EPSDT eligible providers. Approximately 50% of the private providers have participated in the program. The State pays for all sick children referred. Included as eligible recipients in addition to AFDC are foster children and blind and disabled children under 21 years of age.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*The State has no formal agreements with any agencies. They have experienced no problems working with agencies with verbal agreements. Provider numbers are given to all Health Departments and Medichex exams are provided as required by schools.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*The State has no contracts and have no plans to solicit contracts.*

STATE: Indiana

REGION: V

STATE EPSDT COORDINATOR:

NAME: Ms. Arlene Stratton

TITLE:

AGENCY: Indiana Department of Public Welfare

ADDRESS: 100 North Senate Avenue, Room 702

Indianapolis, Indiana 46204

PHONE: 317-232-4315

1. AGENCY ADMINISTERING EPSDT IS:

2. PROGRAM IS: State Supervised/County Administered

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 60,603 (AFDC recipient family cases,  
foster children and medical only.)

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

X  AFDC intake interviews

Other outreach activities (specify):

Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

Physicians  
Health Department  
Comprehensive Providers  
Other (specify)

SCREENING

DIAGNOSIS AND  
TREATMENT

Recipients have freedom of choice.  
All Medicaid providers are EPSDT providers  
who do mostly screens. Health Departments  
do immunizations and screens. An  
approximate percentage of provider  
mix is not available.

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*It is the responsibility of all county staff and the State coordinator. Also, the fiscal agent provider relations group conduct recruitment meetings with providers. The State does not have a provider problem.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*A dental consultant was available for consultation.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>  </u> Automated?	<u>  </u> Both?
<u>  X  </u> Manual?	<u>  </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Some consideration has been given to moving into an automated system. No firm plans have been made.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Training is provided by the State coordinator on the average of once a month to county staff when an adequate number of staff has reported.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*The State does not feel that they excell in any particular area. State Coordinator has no areas of expertise which she feels would be beneficial to other State programs.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*There is an excellent working relationship with Social Service Agency, however, there is no interagency agreement.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*The State has no agreements and there are no plans to make any agreements.*

STATE: Iowa

REGION: VII

STATE EPSDT COORDINATOR:

NAME: Ms. Kathi Kellen

TITLE: Bureau of Medical Services

AGENCY: Department of Social Services

ADDRESS: Hoover State Office Building

Des Moines, Iowa 50319

PHONE: 515-281-8795

1. AGENCY ADMINISTERING EPSDT IS: *Umbrella*
2. PROGRAM IS: *State Administered*
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *69,000*
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  X   AFDC intake interviews

       Other outreach activities (specify):

       Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	75%	No diagnosis and treatment breakdown available.
Health Department		
Comprehensive Providers		
Other (specify) <i>Screening Centers</i>	25%	

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*All physicians are eligible to participate. Other providers, Health Department, Schools, etc., are recruited as interest is shown with assistance from Kansas City regional office.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*EPSDT - Advisory Committee, although its not particularly active. Local medical providers.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>  X  </u>	Automated?	<u>      </u>	Both?
<u>      </u>	Manual?	<u>      </u>	Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Continuing to debug.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*A course for Income Maintenance Workers about three times per year. Working on a programmed learning booklet for new workers (very early stages-planning).*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

1. *EPSDT - Advisory Committee - but it still needs work to involve more private practitioners.*
2. *Using schools as screening centers.*
3. *Case management automated.*
4. *Interagency with Maternal & Child Health agreement in process.*
5. *Current training program for IM workers but this needs to be revamped.*
6. *Problem with Health Department physician control; the need to involve more areas and private physicians.*

11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*MCH completed*

*CCS completed*

*One School District*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*Working on an administrative agreement with School Districts.*

STATE: *Kansas*

REGION: *VII*

STATE EPSDT COORDINATOR:

NAME: *Ms. Emily Russell*

TITLE: *Medical Services Section*

AGENCY: *Department of Social and Rehabilitation Services*

ADDRESS: *State Office Building*

*Topeka, Kansas 66612*

PHONE: *913-296-3981*

1. AGENCY ADMINISTERING EPSDT IS: *Social Service/Welfare*

2. PROGRAM IS: *State Administered*

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *66,000*

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  *x*   AFDC intake interviews

       Other outreach activities (specify):

       Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

Physicians  
Health Department  
Comprehensive Providers  
Other (specify)

<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
------------------	------------------------------------

*Currently unavailable*

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

State representatives attend meetings of professional societies. State has pediatrician on the Child Health Advisory Committee. State has representatives of EPSDT provider groups on the EPSDT advisory committee. Fiscal agents distribute bulletins to enrolled providers.

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

State wide EPSDT advisory committee. Professional interagency groups affiliated with child health and development. Input from dental advisory and State medical advisory committee.

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u> Automated?	<u>      </u> Both?
<u>      </u> Manual?	<u>  X  </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

Work is needed to make the EPSDT subsystem useful.

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

Training is provided to field staff and manuals are updated periodically.

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

- o State physicians' program encourages recipients who are patients to enter the EPSDT program, and encourages EPSDT recipients to establish a medical home.
- o EPSDT participants are eligible for medical and dental services which are covered only for EPSDT participants.
- o Some Home Health Agencies are providing EPSDT screening services.

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

Medical Services Section has a working agreement with the Department of Health and Environment.

MS has working relationship with (1) Special Education for Early Identification and Intervention of Childhood Handicapping and (2) Head Start for screening coordination.

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

Interagency agreement with the Department of Health & Environment is part of the State Health Plan.

Interagency agreements with:

1. Crippled Children's Service
2. Title V-XIX
3. Some local agencies have contracts with some local health departments for providing outreach.

STATE: *Kentucky*

REGION: *IV*

STATE EPSDT COORDINATOR:

NAME: *Ms. Buena Bishop*  
TITLE: *Bureau for Social Insurance*  
AGENCY: *Department of Human Resources*  
ADDRESS: *DHR Building*  
*Frankfort, Kentucky 40601* PHONE: *502-564-3476*

1. AGENCY ADMINISTERING EPSDT IS: *Umbrella*
2. PROGRAM IS: *State Administered*
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *156,000*
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  *X*   AFDC intake interviews

       Other outreach activities (specify):

  *X*   Other: *Also 1 year by mail*

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians		<i>100%</i>
Health Department	<i>100%</i>	
Comprehensive Providers		
Other (specify)		

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Health Departments and School Boards participate. State mails announcements out to physicians and solicits physicians by mail.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Very little*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u>	Automated?	<u>  X  </u>	Both?
<u>      </u>	Manual?	<u>      </u>	Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:  
*Will be linked to MMIS. State is awaiting Federal announcements on GSD requirements.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Workshops for RN's in audiometric, vision, and other assessment features of programs. State mails out updated information which constitutes a form of continuing education.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*Biggest problem in the past has been outreach and case management. Clients tend to have a 50 percent no show rate. Low client response to physician services has increased the tracking load to caseworker and done little to sustain any enthusiasm which providers may have.*

11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*Currently Bureau of Health Services works closely in screening.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*There is a new contract with the Bureau of Health Services to do outreach and follow up.*

STATE: *Maine*

REGION: *I*

STATE EPSDT COORDINATOR:

NAME: *Ms. Edna Jones*  
TITLE: *State EPSDT Coordinator*  
AGENCY: *Bureau of Medical Services*  
ADDRESS: *Department of Human Services*  
*State Office Building*  
*Augusta, Maine 04333*

PHONE: *207-289-2674*

1. AGENCY ADMINISTERING EPSDT IS: *Health*
2. PROGRAM IS: *State Administered*
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *52,296*
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

       AFDC intake interviews

  X   Other outreach activities (specify): *The Department has contracts with 13 agencies, such as, Community Action Programs (C.A.P.) and Home Health Agencies to do informing through home visits once eligibility has been determined.*

       Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians ( <i>R.H.I.s</i> )	95%	98%
Health Department	0%	0%
Comprehensive Providers	0%	0%
Other (specify) <i>Child Health Conferences</i>	5%	0%
<i>Hospital Outpatient Departments and</i>		
<i>Child Development Centers</i>	0%	2%

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*The number of providers in the State is small. When a new provider moves into the State, he/she is introduced to the program by the medical/dental community in the area.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*The Health Standards Council composed of representatives of the physician, dental, and nursing communities developed the periodicity schedule and the health standards. The health standards are in the process of being revised and will be sent to the main chapters of the American Medical Association, the Academy of Pediatrics, the Family Practice Association, and the Association of Osteopaths for input. Also, the Dental Association did not feel the fee schedule was equitable and interceded to have legislation passed raising the reimbursement schedule.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u> Automated?	<u>      </u> Both?
<u>  X  </u> Manual?	<u>      </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*The State is planning on enlisting provider cooperation in terms of listing the screening package given on the billing form so this data can be put on computer. The State is also hoping to computerize periodicity lists.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Staff development is done primarily by 13 contracting agencies. These agencies may send staff to workshops to acquire skills related to EPSDT. These courses require prior approval in order to be paid. The State EPSDT Coordinator also meets with local program coordinators throughout the State 6 to 8 times per year.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*Outreach and case management are the strongest points in the Maine EPSDT program. The agency contracts with 13 agencies who inform families in their home once eligibility has been reached. This atmosphere allows development of patient education and a strong personal sense in arranging for transportation, locating a provider, and scheduling. It also lends to excellent follow-up by outreach workers.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*At the State level there are agreements with Title XIX and Title XX for the provision of transportation, Title XIX and Vocational Rehabilitation, Title XIX and the Department of Education, and Title XIX and Title V.*

*On the local level, local coordinators establish linkages with local agencies, such as, Family Planning and Head Start.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*Contracts exist with 13 agencies, i.e., Community Action Programs and Home Health for outreach and case management.*

STATE: Maryland

REGION: III

STATE EPSDT COORDINATOR:

NAME: Ms. Amy Chapper  
TITLE: Department of Health and Mental Hygiene  
AGENCY: Medical Assistance Policy Administration  
ADDRESS: 201 West Preston Street, 1st Floor  
Baltimore, Maryland 21201 PHONE: 301-383-2658

1. AGENCY ADMINISTERING EPSDT IS: Health
2. PROGRAM IS: State Administered - through contract
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 182,943 (as of July 1981)
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  X   AFDC intake interviews

  X   Other outreach activities (specify): Contractor does informing  
at DSS office and door-to-door face-to-face.

  X   Other: Pamphlets explaining EPSDT program are mailed with Medical  
Assistance cards every two months and distributed at local DSS  
offices.

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	81% (145)	Services may be
Health Department	13% ( 24).	provided by any
Comprehensive Providers	6% ( 10)	Medical Assistance
Other (specify)		provider.

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

- Contractor (AHSI) has recruitment responsibility. Regional provider relation specialists are assigned within each region to contact and recruit providers.
- Contractor maintains monthly communication with all EPSDT providers to assure retention.
- Agency assists the contractor in recruitment efforts by contacting providers by direct mail and through medical societies.

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

Currently, ongoing input from State/local medical community provided through monthly meetings of EPSDT Advisory Committee on Provider Relations. Prior to formation of this committee local medical societies, Maryland Medical and Chirurgical Faculty, and providers from both public and private sector had significant input in design of medical and provider aspects of program.

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u> Automated?	<u>  X  </u> Both? - Contractor does the tracking
<u>      </u> Manual?	<u>      </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

Due to the comprehensive medical standards mandated by program, DHMH provides training for contractor's provider relations specialists. The contractor then provides administrative and technical medical training to providers and their staffs. Contractor also provides training for its outreach workers using a training manual and formal training program.

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

Program Design. Implemented use of new form which permits agency to identify screening services provided and to track the client, as well as enable provider to bill for services. This new form consolidates three previous forms.

Case Management. Contractor has total case management system which handles everything from screening through diagnosis and treatment to the tracking of EPSDT participants. It also provides for support services of transportation and scheduling upon request. Invoice processing and data reports are provided for DHMH.

Service Delivery. State has had success with encouraging providers to do a complete screening in one visit.

Quality Assurance. Nursing staff from Preventive Medicine Administration make yearly on-site visits to each EPSDT provider to assure delivery of quality care.

Provider Manual. State has compiled an EPSDT Provider Manual detailing screening procedures for use by providers and their staffs.

Outreach/Informing. In addition to pamphlets describing EPSDT services which are mailed out bi-monthly with Medical Assistance cards, outreach is performed by contractor face-to-face in eligibles' homes and to lesser degree at DSS offices. Pamphlets and other materials are left when eligibles are not home.

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

DHR - list of eligibles provided for use by the contractor.

Department of Education - (planned) to coordinate referral of children identified through EPSDT to Child Find early identification program.

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

Automated Health Systems (AHS) - to provide outreach, case management, appointment and transportation assistance to eligibles; reports, invoice processing, and provider recruitment for DHMH.

Local Health Department - to provide EPSDT services.

Head Start - agreement to establish a working relationship to provide maximum medical screening, diagnosis, and treatment services to eligible residents.

Preventive Medicine Administration (another administration with DHMH) - to act as medical consultants for the EPSDT program.

STATE: *Massachusetts*

REGION: *I*

STATE EPSDT COORDINATOR:

NAME: *Ms. Lynn Carsten*  
TITLE: *Director, Project Good Health*  
AGENCY: *Department of Public Welfare*  
ADDRESS: *600 Washington Street, Room 740*  
*Boston, Massachusetts 02111* PHONE: *617-727-8084*

1. AGENCY ADMINISTERING EPSDT IS: *Social Service/Welfare*

2. PROGRAM IS: *State Administered*

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *313,847*

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  *X*   AFDC intake interviews

  *X*   Other outreach activities (specify): *Department of Social  
Services informs and assists foster children.*

  *X*   Other: *Department of Public Health informs and assists S.S.I.*

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
* Physicians	97%	
Health Department		
Comprehensive Providers		
Other (specify) <i>School Demonstration</i>	3%	
<i>Project; Community Health Centers</i>		

*\*Physicians who provide screening also provide diagnosis and treatment.*

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*New regulations effective June 1, 1981 will permit any Medicaid physician, C.H.C., or family planning agency to bill for EPSDT services. A staff of four promotes these new arrangements with providers and is training the providers in new procedures.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Massachusetts State Chapter of A.A.P. has been consulted in development of protocol and periodicity schedule and in design of billing/tracking forms and procedures.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u> Automated?	<u>      </u> Both?
<u>  X  </u> Manual?	<u>      </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*July 1, 1981 - target for full operation of computerized billing/tracking/information system.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Project Good Health conducts specific training. The training unit of the Department of Public Welfare trains new assistance payment workers.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*Case management staff is located in 38 sites around the State. This staff provides outreach to all eligible families and assists those who request EPSDT to obtain screening and needed diagnosis and treatment.*

*Providers capable of rendering full EPSDT services are encouraged to participate by an incentive payment over and above the regular fees for routine service.*

*Four full time staff members recruit and train providers in billing procedures for EPSDT services. The provider relations staff gives individual assistance when providers have difficulties with the new billing system.*

*Computerized information system will input data from case management staff and from providers' billing claims to track children through the EPSDT service cycle. This system provides reports which will trigger case management steps. The system will also provide management information.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*Interagency agreement with Massachusetts Department of Social Services delegating to D.S.S. EPSDT case management activities for foster children who are in the care of D.S.S. The D.P.W. provides the D.S.S. with outreach and informing material, staff training, and information system support for follow-up.*

*Interagency agreement with Massachusetts Department of Public Health provides for referral of EPSDT eligible children to Title V agencies and delegates certain case management activities to Title V agencies. The agreement also provides that the D.P.H. will inform SSI-DC regarding EPSDT services.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*None*

STATE: Michigan

REGION: V

STATE EPSDT COORDINATOR:

NAME: Mr. Bill Keller  
TITLE: Medical Services Administration  
AGENCY: Department of Social Services  
ADDRESS: P. O. Box 30037  
Lansing, Michigan 48910

PHONE: 517-373-7720  
FTS 253-7720

1. AGENCY ADMINISTERING EPSDT IS: Social Service/Welfare

2. PROGRAM IS: State Administered

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21:

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  X   AFDC intake interviews

  X   Other outreach activities (specify): Computer is programmed to  
determine eligible Title XIX recipients monthly.

       Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	0%	100%
Health Department	90%	0%
Comprehensive Providers (PRESCAD)	2%	0%
Other (specify) HMO, Private Clinics, Sister of Mercy Clinic	6%	0%

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Medicaid providers are recruited through seminars and retained by payment of claims within 15 days and allowing providers 12 months to bill. EPSDT screening clinics are reimbursed for making appointments available and so have the convenience of knowing what funds are available for 1 year, because screening contracts are for the fiscal year.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Members of the Michigan Chapters of the American Medical Association, Osteopathic Physicians, and the Dental Associations were consulted in establishing Michigan's periodicity schedule.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>          </u>	Automated?	<u>  X  </u>	Both?
<u>          </u>	Manual?	<u>  X  </u>	Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*No*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*The Michigan Department of Public Health has training in all phases of EPSDT screening at least three times during a calendar year.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*The EPSDT system is a subsystem of MMIS. This assures that the information submitted to outreach staff is accurate and timely. The computer preprints the EPSDT case summaries for those recipients due for screening because they are newly eligible/reopened Medicaid cases, are due under Michigan's periodicity schedule, or did not participate in EPSDT during the last 12 months. At the same time, a computer generated informing letter is sent to the families/recipients. This letter serves to remind families, informed about EPSDT at intake of services available and notified persons due under the periodicity schedule or nonparticipations within past 12 months of EPSDT.*

*We believe the interaction of case management/MMIS and outreach make the Michigan EPSDT program effective.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*The Michigan Department of Social Services and the Michigan Department of Public Health have an interagency agreement which explains the responsibilities of both departments in regard to EPSDT and its interaction with Title V.*

*Head Start/EPSDT agreement is in process of development.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*The Michigan Department of Public Health has contracts with various local health departments/districts to provide EPSDT screenings.*

STATE: Minnesota

REGION: V

STATE EPSDT COORDINATOR:

NAME: Ms. Karen Collinson

TITLE:

AGENCY: Department of Public Welfare

ADDRESS: Space Center Building, 2nd Floor  
444 Lafayette Road  
St. Paul, Minnesota 55101

PHONE: 612-296-6955

1. AGENCY ADMINISTERING EPSDT IS: Social Service/Welfare

2. PROGRAM IS: State Supervised/County Administered

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 111,671

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

X AFDC intake interviews

X Other outreach activities (specify): Coordination with Head Start,  
Pre-school screen, EPSD clinics, WIC, postnatal follow-up.

X Other: Identified by physicians and clinic screeners.

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	61%	95%
Health Department	32%	
Comprehensive Providers		
Other (specify): HMO, C&Y, MIC	6%	5%

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*New Medicaid enrollees are contacted by mail survey and in follow-up personal interviews by State EPSDT staff to sign EPSDT provider agreements. Word of mouth and referrals by other providers result in additional recruits. Periodic contact by newsletter and annual training and retraining on EPSDT components aids retention.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*State and local medical and dental associations are represented on advisory committees and were represented on group which drafted the Statewide EPSDT screening standards. Medical and dental groups testified at rule hearing which established the program. When special issues need interdisciplinary input, subcommittees representation is sought.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>          </u>	Automated?	<u>      X      </u>	Both?
<u>          </u>	Manual?	<u>      X      </u>	Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Unknown*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*County personnel receive quarterly technical assistance and training from State EPSDT personnel. Training sessions are conducted biannually or more often as needed due to manual or regulation updates.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



## 10. (Continuation Sheet for Description of Effective Practices).

### EFFECTIVE PRACTICES IN EPSDT

#### Preventive Health Packets

- a pocket folder containing dental coloring book, nutritional and immunizational information
- to be given to families who decline EPSDT services and/or as an additional outreach tool

### CASE MANAGEMENT

#### Contracted Services

- local welfare agencies contract with local health departments to outreach, track and follow-up
- utilizes health background to explain preventive health
- allows one agency to follow client through entire process
- referral for diagnosis and treatment handled by health professional

#### Tracking System

- manual system with automated components
- uniform reporting for all counties
- eases information exchange between counties
- automated re-informing based on periodicity of screens

#### PSS/EPS

- utilize manual tracking records to follow results of diagnosis and treatment and special education evaluations

#### Uniform Claim Form

- once claim is processed, same form is utilized by CWD to follow-up referrals for diagnosis and treatment
- processing of claim form suppresses renotification
- coordination of three screening programs reduces duplication of service

### SERVICE DELIVERY

#### Provider Enrollment and Retention

- one-to-one contact, enrollment and follow-up
- providers recruit EPSDT participants
- monetary incentives utilized for outreach and follow-up by providers
- offer DDST and other screening tools, free-of-charge
- offer annual screening skills training with CE credits
- offer periodic claims processing training
- periodic Newsletter to update providers and feature a screening component

#### Collaborative Services with Health and Education

- three screening programs EPSDT, EPS , PSS are equivalent
- uniform reporting form
- data collection through one system
- reduces duplication
- on-going training provided for nurse screeners in total screening skills and in specific areas such as parenting, cardio-vascular, etc.

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*Agreement with Minnesota Department of Health to:*

- provide training to EPSDT providers*
- provide outreach materials*
- provide program evaluation report*
- service provider*

*Linkage with Minnesota Department of Education, Head Start, Title V clinics serve as providers.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*Contract with Minnesota Department of Health specified above.*

*Supervise the contractual agreements between County welfare and health agencies.*

STATE: *Mississippi*

REGION: *IV*

STATE EPSDT COORDINATOR:

NAME: *Ms. Virginia Walker*  
TITLE: *Assistant Administrator EPSDT*  
AGENCY: *Mississippi Medicaid Commission*  
ADDRESS: *P.O. Box 16786*  
*Jackson, Mississippi 39206* PHONE: *601-354-7464*

1. AGENCY ADMINISTERING EPSDT IS: *Single State Agency*

2. PROGRAM IS: *State Administered*

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *157,000*

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  *X*   AFDC intake interviews

  *X*   Other outreach activities (specify): *Non-participators are out-reached again by screening providers.*

       Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	2%	2%
Health Department	94%	94%
Comprehensive Providers	2%	2%
Other (specify): <i>R.N. Clinics</i>	2%	2%

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Mailing of informing materials soliciting participation, contacts with State and local professional groups and face-to-face meetings with single providers in areas which are very under served.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*T.A. Committees for physician services, dental and optometric services. These are standing committees composed of representatives from the various associations, The Governor's appointees and the Commissioner's appointees. The EPSDT Coordinator sits on each of these committees.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>          </u>	Automated?	<u>     X     </u>	Both?
<u>          </u>	Manual?	<u>     X     </u>	Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Manual tracking in each county will be accomplished by July 1, 1981 as newly budgeted positions are filled. Automated information regarding problems found now in place (3/1/81) with treatment received from billing file.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*None*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*Expect to be able to furnish providers with an ongoing timely screening list of eligibles who they are carrying.*

*State will have the capability and would like to furnish providers a list of declining eligibles but must await clearance from HCFA and interpretation of Federal policy.*

*Use HCFA 156 as a source of information to share with other health agencies within State and for agencies own purposes. State is currently debugging and improving system.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

1) *State Board of Health: screening, family planning services, Title V linkages, follow-up (case management) services.*

2) *State Dept. Public Welfare: informing and transportation services.*

B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

1) *Friends of Children: screening services for a county area Head Start centers.*

STATE: *Missouri*

REGION: *VII*

STATE EPSDT COORDINATOR:

NAME: *Ms. Kris Frank*

TITLE:

AGENCY: *Department of Social Services*

ADDRESS: *227 Metro Drive*

*Jefferson City, Missouri 65101*

PHONE: *314-751-2447*

1. AGENCY ADMINISTERING EPSDT IS: *Social Service/Welfare*

2. PROGRAM IS: *State Supervised/County Administered*

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *165,000*

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  X   AFDC intake interviews

       Other outreach activities (specify):

       Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	40%	100%
Health Department	30%	
Comprehensive Providers		
Other (specify) <i>Metro Public</i>	30%	
<i>Schools</i>		

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Through the State's general Title XIX (Medicaid) recruitment.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*EPSDT advisory committee meets quarterly. This includes representatives from all of the State, local, medical, and dental community. These representatives set policy standards, design forms, and make specific recommendations on the periodicity schedule.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>  X  </u>	Automated?	<u>      </u>	Both?
<u>      </u>	Manual?	<u>      </u>	Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*System is constantly being modified.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Basic orientation training, which includes EPSDT, is given to individual staff. State has a videotape on EPSDT at all county offices.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*The State has not invited EPSDT providers of any particular type. All Title XIX providers may do EPSDT. The State has paid data processing and is focused on provider needs.*

11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*Missouri State Department of Social Services has cooperative with three large school districts within the State. There are also working agreements with:*

- 1. Head Start*
- 2. Department of Health*
- 3. Local agreements with three job corps centers in the State*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*None*

STATE: *Montana*

REGION: *VIII*

STATE EPSDT COORDINATOR:

NAME: *Mr. Dale Haefer*

TITLE: *Department of Social and Rehabilitation*

AGENCY: *Services*

ADDRESS: *P. O. Box 4210*

*Helena, Montana 59601*

PHONE: *404-449-4540*  
*FTS 587-4540*

1. AGENCY ADMINISTERING EPSDT IS: *Social Service/Welfare*

2. PROGRAM IS: *State Supervised/County Administered*

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *17,222*

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  *X*   AFDC intake interviews

  *X*   Other outreach activities (specify): *Contracts for outreach  
with local social service agencies.*

       Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	<i>0%</i>	<i>90%</i>
Health Department	<i>90%</i>	<i>0%</i>
Comprehensive Providers	<i>10%</i>	<i>10%</i>
Other (specify)		

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Based on contracts with local health departments. This area not particularly a problem except where no local county health department exists.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Originally, advisory committee when setting-up the program and developing a mid-level practitioner model. Subsequently little involvement.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>          </u>	Automated?	<u>      X      </u>	Both?
<u>          </u>	Manual?	<u>      X      </u>	Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Yes, but not yet developed. Awaiting potential changes in Federal rules and regulations regarding monitoring.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*None formalized. Done as needed.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

One organizational model being attempted is in conjunction with local schools, Head Start, Tribal Health, Indian Health, and other agencies involved with screening in Region I of Montana (eastern 17 counties). The service contract is with a Public Health Service research and demonstration project and has as an objective the integration of fragmented screening efforts into a cohesive network. This is based on an all community screening model. All children are eligible; administratively, they can be counted by whatever agency wishes to count them. This model would be effective in a highly rural area such as Region I of Montana. This region is the size of Pennsylvania with a total population of about 100,000. There are no towns over 10,000 population.

Another organizational model under experiment is contracting with a major city/county health department, e.g., Butte-Silver Bow, population 40,000, to create a mini-region of the major county plus adjoining rural counties. This catchment area concept, including both outreach and screening services, allows service to be available on a continuing basis.

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*SEA - Office of Public Instruction - preschool screening.  
Indian Health Services - IHS/EPSDT screenings.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*State Department Health - screening in specific counties.  
City-County Health Departments - 15 contracts for outreach and screening services.  
Federal R&D Projects - 3 Public Health Service projects - contracts.  
Outreach contracts (5) - local social service agencies.*

STATE: Nebraska

REGION: VII

STATE EPSDT COORDINATOR:

NAME: Ms. Sandi Kahlandt  
TITLE: Medical Services Division  
AGENCY: Department of Public Welfare  
ADDRESS: 301 Centennial Mall, South  
Lincoln, Nebraska 68509

PHONE: 402-471-3121, ext. 362

1. AGENCY ADMINISTERING EPSDT IS: Social Service/Welfare

2. PROGRAM IS: State Supervised/County Administered

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 28,339

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

☒ AFDC intake interviews

☒ Other outreach activities (specify): Redetermination

☐ Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	100%	100%
Health Department		
Comprehensive Providers		
Other (specify)		

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*All Title XIX providers are also EPSDT providers.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Dental Society has been contacted and key members of the Medical Association (AAP) have been asked to advise on such matters as periodicity schedule. Other relevant interest groups are contacted when issues concerning them arise.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u>	Automated?	<u>  X  </u>	Both?
<u>      </u>	Manual?	<u>      </u>	Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Upgrades in the system are planned as necessary. Debugging is ongoing.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*There are State and County worker training sessions for EPSDT. New caseworkers receive an orientation on EPSDT. There are handbooks for workers dealing with EPSDT.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

1. *Some counties have a caseworker assigned to perform EPSDT exclusively.*
2. *There is a central State EPSDT information linkage and central communication network.*
3. *There is a trend in the State to make EPSDT the core of the child health and development component of the welfare assessment program.*
4. *There is one screening claims form which shows both findings and claims.*
5. *State has a good tracking system which shows overdue screening listings.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.
1. *EPSDT with MCH, City Health Department, Dental Project, and Title V programs, respectively.*
  2. *EPSDT/SCC - crippled children.*
  3. *Omaha Douglas County Health Department.*
  4. *Indian Health Facilities.*
  5. *Working on obtaining an agreement with WIC.*
  6. *HUD.*
- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.
1. *Omaha/Douglas County Agreement - fee schedule under review.*
  2. *C&Y/Health Department negotiating a fee schedule.*
  3. *Looking at the possibility of providing EPSDT through home health unit. (This may not happen.)*
  4. *Need to link up with the school system.*

STATE: Nevada

REGION: IX

STATE EPSDT COORDINATOR:

NAME: Ms. Eloise Harris, R.N.

TITLE: EPSDT Coordinator, Medical Care Section

AGENCY: State Welfare Division

ADDRESS: 251 Jeanell Drive

Capital Complex

Carson City, Nevada 89710

PHONE: 702-885-4775

1. AGENCY ADMINISTERING EPSDT IS: Social Service/Welfare

2. PROGRAM IS: State Administered

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 8,000-10,000

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

☒ AFDC intake interviews face to face.

☒ Other outreach activities (specify): computer mailouts at set intervals.

☐ Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	80%	100%
Health Department		
Comprehensive Providers	10%	
Other (specify) Nurses, Independent	10%	
Nurse Practitioners		

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Personal face to face contact by EPSDT Coordinator. Overabundance of providers state-wide. Physicians have done a total turn around in the last 5 years. Face to face contact responsible for this turnaround.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*For any changes which require medical/dental input, the coordinator will personally solicit an opinion on an individual basis.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u>	Automated?	<u>  X  </u>	Both?
<u>      </u>	Manual?	<u>      </u>	Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Manual review of each screen by R.N. Results are computerized. All remaining case management functions are computerized. Will eventually be linked to MMIS.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Ongoing training for new eligibility personnel. Each district has training by Central Office, according to need.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*Value of the Nevada system is minimization of fragmentation and treatment of the child as a whole. Encourage total screen by allowing a dollar amount that is conducive. Have proved to be cost-effective in the long run by being able to treat the child while still eligible for benefits. State will rush treatment if there is danger of loss of eligibility.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*Headstart - every summer the agency receives a list of all Medicaid eligibles so that screenings can be conducted. This occurs both with Intertribal Council and State Department of Education.*

*High Risk Infants - doctors will get the babies screened before infants leave the risk center. Helps get the mother necessary continuing care.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*Contract with State Health Department to decrease duplication.*

*Improved Pregnancy Program - high risk young women who have had no medical care. EPSDT pays for the physical which is equivalent to the screen. Introduces these women to comprehensive care.*

STATE: *New Hampshire*

REGION: *I*

STATE EPSDT COORDINATOR:

NAME: *Ms. Judith Lanouette Nicholson*

TITLE: *EPSDT Coordinator*

AGENCY: *Division of Welfare*

ADDRESS: *Hazen Drive*

*Concord, New Hampshire 03301*

PHONE: *603-271-4350*

1. AGENCY ADMINISTERING EPSDT IS: *Umbrella*
2. PROGRAM IS: *State Administered*
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *16,000*
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  *X*   AFDC intake interviews

  *X*   Other outreach activities (specify): *In their own homes after eligibility has been determined.*

       Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	95%	99%
Health Department (C&Y providers)	5%	1%
Comprehensive Providers		
Other (specify)		

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

- 1) Nurse consultants visit non-participating physicians to inform them of EPSDT program and act as liasons with participating physicians.
- 2) The State Pediatric Society informs new pediatricians in State of EPSDT program and encourages them to participate.

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Input by State Pediatric Society regarding periodicity schedule and the screening package. State Dental Society, the Division of Child Dental Corporation were members of a committee which had input regarding periodicity schedule and the dental package.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>          </u> Automated?	<u>     X     </u> Both?
<u>          </u> Manual?	<u>     X     </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*There are certain enhancements of computer system planned, i.e. improving reports to new recipients, reminder letters and notices being printed by computer, and other clerical improvements. However, no specific dates are available.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

- 1) October 1980 - week long session for all field staff.
- 2) Nursing consultants visit field offices twice a month and provide training as needed.
- 3) Quarterly sessions are held at the State Office.

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

- 1) There are 16,000 children eligible for EPSDT services in the State of New Hampshire. The EPSDT program has fourteen outreach workers and three nursing consultants. Each field workers' caseload is manageable and permits the worker to follow cases carefully and to go the "extra length" should a case warrant it.
- 2) In Northern counties, where caseload are lower, outreach workers make home visits and interview families after eligibility has been determined.
- 3) The EPSDT program is located within the State Department of Public Welfare which has proved to be advantageous to the program, because access is readily available to files and case eligibility determination is known to the program within one or two days.
- 4) The State Pediatric Society is extremely supportive of the EPSDT program in the State.

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*There is an Interagency Agreement with the Division of Welfare and the Division of Public Health. Subagreements exist between Medicaid and the Office of Maternal and Child Health, Medicaid and the Bureau of Handicapped Children's Services, Medicaid and the Division of Vocational Rehabilitation, and Medicaid and the Bureau of Dental Services. A Memorandum of Understanding exists between Medicaid and SSI.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*None*

STATE: New Jersey

REGION: II

STATE EPSDT COORDINATOR:

NAME: Ruth Stekert, M.D.  
TITLE: Director, Child Health Medical Assistance Program  
AGENCY: New Jersey Medicaid Program  
ADDRESS: 324 East State Street  
Trenton, New Jersey 08625  
PHONE: 609-292-8197  
FTS 477-8197

1. AGENCY ADMINISTERING EPSDT IS: *Umbrella\**
2. PROGRAM IS: *State Administered*
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21:
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK): *428,000*

  X   AFDC intake interviews (*Annual Brochure*)

       Other outreach activities (specify):

  X   Other: *County Welfare Agency, T.V. publication, radio, fair, audio visual*

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	88%	99%
Health Department	9%	0%
**Comprehensive Providers	2-1/2%	0%
Other (specify) <i>Hospital OPD</i>	1/2%	1%

*\*Single State Agency Administration, Department of Human Services, Division of Medical Assistance.*

*\*\*Other Than Private Practitioners - contract with other agencies, we are payer.*

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Physician provider relations are routinely maintained by our staff physician, local and regional medical consultants, and EPSDT field coordinators. Routinely and through special projects recruit and relate to providers; a provider enrollment unit handles facility provider applicants.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Regular meetings through the year are held with the Child Health Advisory Committee (includes representatives from New Jersey Chapter of AAP, Osteopathic Society, and Pediatric Dentists). Meetings are held as necessary with the New Jersey Medical Society.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>          </u>	Automated?	<u>      X      </u>	Both?
<u>          </u>	Manual?	<u>      X      </u>	Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*An upgraded automated case management system was designed, but no implementation date is possible to determine until after sunset review results.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*A staff EPSDT trainer cooperates with the Bureau of Child Health in developing and implementing EPSDT training for local county worker staff. Bureau field service coordinators follow-up on an on-going basis for day to day needs.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

Program Design. New Jersey has developed a system design which contains the following elements directed to efficient operation, evaluation, and client freedom of choice, i.e., EPSDT and child health service delivery.

- a. A single comprehensive assessment procedure use for EPSDT or non-EPSDT preventive health assessment request.
- b. An Automated EPSDT Request File/Data Store.
- c. Monthly output lists/reports from Data Store to the counties to provide outreach and tracking information. This system would have the capability to produce a separate/parallel tracking mechanism for all non-EPSDT client initiated assessments under a system of equivalent/continuing care.

Service Delivery. A provider participation demonstration project is being developed, in which higher reimbursement fees would be paid to a group of physicians for primary care services available to children on a 24-hour basis. The objective of the demonstration is to show that the cost savings from elimination/minimization of emergency room visits could be passed to the physicians via higher reimbursement.

EPSDT Administrative Support Services. Seventy-five (75) percent is available for the salaries, training, and travel of county workers assigned to EPSDT units in each County Welfare Agency (CWA). This concentration of EPSDT county staff has increased the efficiency of support services for delivery of EPSDT. The State Bureau of Child Health employs five regional field service coordinators who provide an essential linkage between the State and county agencies.

School Health Demo Project. New Jersey has developed and implemented an agreement with a school district and the local CWA in which the school provides EPSDT equivalent services to all school children. Via a list of students sent to the CWA, Medicaid eligible children enrolled at the school thereby receiving EPSDT equivalent services are identified at the CWA EPSDT unit and registered into the State EPSDT computer system as EPSDT participating children. Thus, existing school health service prevents duplication of medical, outreach, and support services by the CWA.

Reimbursement to the school is for administrative costs at \$2 for each Medicaid eligible child, based on the estimated number of such children screened during the school year. In return, the school keeps records which reflect EPSDT documentation requirements, and makes them available for Federal and State review to assure that EPSDT equivalent performance standards are being met.

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*Title V - Title XIX agreement for mutual identification and referral of Title V and Title XIX children for EPSDT or MCH services by the State Medicaid and State MCH/CCP agencies through their respective local service agencies.*

*Title XIX - State Vocational Rehabilitation Agency. Same basic format and content as in the agreement with Title V.*

*State Medicaid - Public Welfare - Youth and Family Services, and County Welfare Agency agreement for provisions of EPSDT and Family Planning. Administrative Support Services. Each CWA has an EPSDT unit. CWA claims for 75 percent FFP under Title XIX are processed by Public Welfare and Medicaid.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*New Jersey employs two program contractors. Blue Cross for maintenance of Medicaid eligible file and claims processing of certain program providers; Prudential Insurance Company for operation of the current EPSDT subsystem and claims processing of certain program providers.*

STATE: New Mexico

REGION: VI

STATE EPSDT COORDINATOR:

NAME: Mr. Carlos Fierro  
TITLE: EPSDT Coordinator  
AGENCY: Department of Human Services  
ADDRESS: Room 515-PERA Building  
P.O. Box 2348  
Santa Fe, New Mexico 87503

PHONE: 505-827-5551  
FTS 8-476-5551

1. AGENCY ADMINISTERING EPSDT IS: Umbrella
2. PROGRAM IS: State Supervised/County Administered
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 47,000
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

X AFDC intake interviews

X Other outreach activities (specify): PSA, TV Spots, Social Services, Foster Care, schools with interagency agreement for health education and meetings with administrators.

X Other: During visits to health clinics.

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	90%	90%
Health Department		
Comprehensive Providers	5%	5%
Other (specify) Indian Health Service	5%	5%



6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*State coordinator has visit with each provider and calls once per month. Letters provide updates, ask for referrals and express appreciation. New doctors are contacted based on information from the Board of Medical Examiners. Agreements are in effect for Indian Health Service and Head Start.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Coordinator attends one annual State Medical Society meeting to inform about EPSDT. Program relies on the Medicaid Advisory Committee because formation of an EPSDT Medical Consultant Group with one provider from each county is still in development.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u> Automated?	<u>      </u> Both?
<u>  X  </u> Manual?	<u>      </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Design of an automated system linked to MMIS is ready, but implementation is delayed by the shortage of in-house programmers and need to train staff.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Although a program goal, staff development has not been funded.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

- 1) *Extremely effective public service announcements have been developed using donated services of Ricardo Montalban. These tapes were then adapted to TV Spots and have received even more widespread use. Broadcasts for Pueblo Indians from an Arizona station are planned.*
- 2) *School administrators are contacted on a regular basis to assure that the school staff are aware of EPSDT services.*
- 3) *Donations from corporations have been sought to reward each child who receives an assessment or dental referral. McDonalds may provide 10,000 certificates for a Big Mac and milk. A similar donation from Fisher-Price toys is expected.*
- 4) *Providers are actively sought and their continued participation cultivated by letters and phone calls. In shortage areas, staff from the Medicaid Agency assists providers in conducting special assessment clinics.*
- 5) *New Mexico developed a bilingual roadrunner poster and has distributed 20,000 copies plus the HCFA posters to each provider and many supermarkets and other public places.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*An agreement is now in effect for the Department of Health and Environment, the Crippled Children's Services agency, to follow EPSDT children referred to them after an assessment and to make periodic status reports to EPSDT.*

*EPSDT has agreements with Head Start, Indian Head Start and schools for marketing/outreach to potential eligibles. The two Head Start programs provide transportation and refer families to appropriate providers. These linkages are particularly important for some urban indians who are particularly hard to reach.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

STATE: New York

REGION: II

STATE EPSDT COORDINATOR:

NAME: Ms. Karen Hogan

TITLE: EPSDT Coordinator

AGENCY: Division of Medical Assistance

ADDRESS: New York State Department of Social Services

40 North Pearl Street

Albany, New York 12243

PHONE: 518-474-9249

518-474-9267

1. AGENCY ADMINISTERING EPSDT IS: Social Service/Welfare

2. PROGRAM IS: State Supervised/County Administered

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 900,000

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  X   AFDC intake interviews

  X   Other outreach activities (specify): New York has five outreach demonstration projects currently contracted to do CHAP outreach.

  X   Other: Child Welfare Workers, SDX Lists.

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	*80% - **10%	Not available
Health Department	*20% - **90%	
Comprehensive Providers		
Other (specify)		

\* In upstate New York

\*\* in New York City

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Districts recruit providers in their medical area.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Medical advisory groups contributed significantly to development of CHAP program.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u> Automated?	<u>  X  </u> Both? (depending on district)
<u>      </u> Manual?	<u>      </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Plan to tie a case management system to MMIS and WMS (Welfare Management System).*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*State staff is available for training and technical assistance to all districts.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

Outreach/Informing. New York has designed a very attractive, eye catching pamphlet and poster for promoting the CHAP program. In addition, there are currently 5 CHAP outreach demonstration programs in operation in selected istes in New York, Several of these projects have done an extensive P.R. campagne to promote CHAP. Among the methods used are advertising on subways and buses, design of key chains, and buttons. Development of posters and pamphlets to supplement the State published material.

Case Management/MIS. New York has a unique CHAP claim form that providers who perform CHAP screen are using to report services and claim reimbursement.

Service Delivery. New York recently increased the reimbursement for the CHAP screen that has been a slight incentive for providers to remain in the system.

Program Design. New York requires a CHAP plan for all 58 local districts. This creates a baseline of information for monitoring and holds districts accountable for performance.

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*Plan for additional school health linkages. Currently there is a school health program through the Robert Wood Johnson Foundation operating in one district. Ad Hoc group with DOE, DOH, and DSS.*

*Five CHAP demonstration projects currently do outreach in five separate areas in the State.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*CIDS (Comprehensive Interdisciplinary Developmental Services, Inc.) has effectively administered the CHAP program in one county in New York since 1974 under contract with the county DSS.*

STATE: North Carolina

REGION: IV

STATE EPSDT COORDINATOR:

NAME: Susan Hunt  
TITLE: EPSDT Coordinator  
AGENCY: Department of Human Resources, Division of Medical Assistance  
ADDRESS: 336 Fayetteville Street  
Wake County Office Building PHONE: 919-733-6775  
Raleigh, North Carolina 27601

1. AGENCY ADMINISTERING EPSDT IS: Ubrella
2. PROGRAM IS: State Supervised/County Administered
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 173,552
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  X   AFDC intake interviews

       Other outreach activities (specify):

       Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

*Percentages not known.*

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	350	350 plus
Health Department	84 (covering 100 counties)	
Comprehensive Providers	2	2
Other (specify) : rural health clinics		
Community health centers	25	

(Percentage breakdown  
unavailable)

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Coordination through the Medical and Dental Societies.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*There is a great amount of input from the State agencies who are responsible for the local health departments and social services and the Academy of Pediatrics. We are now working closely with two dental societies to recruit more dentists to accept Medicaid.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u> Automated?	<u>  X  </u> Both?
<u>      </u> Manual?	<u>      </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*No.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Annual workshops across the State. Private providers, health departments and county departments of social services are invited. Technical assistance is provided to counties as requested.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*EPSDT is the only physical which is Medicaid reimbursable besides family planning. Most private providers are pleased with the EPSDT screening fee (23.50 plus laboratory). They also realize that they receive reimbursement for services that used to be provided. We have a good working relationship with the Academy of Pediatrics through a liaison person who I meet with monthly.*

*We developed EPSDT pilot projects in four counties where we assisted county departments of social service and health departments by hiring additional staff through prefunding. With the additional health department and county social services staff, the four counties had a 67% increase in screening. After the project ended, the health departments were able to support their staff because of vendor payments resulting from screening and treatment. DSS and HD are sharing the 25% non-Federal share for staffing the EPSDT outreach workers.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*Memorandums of Understanding (MOU) among DHS, DSS, Services for the Blind.*

*Vocational Rehabilitation*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*Head Start*

STATE: North Dakota

REGION: VIII

STATE EPSDT COORDINATOR:

NAME: Ms. Doris Schell

TITLE: Department of Human Services

AGENCY: Medical Services

ADDRESS: State Capitol - 16th Floor  
Bismarck, North Dakota 58505

PHONE: 701-224-2321

1. AGENCY ADMINISTERING EPSDT IS: Social Services/Welfare

2. PROGRAM IS: State Supervised/County Administered

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 9,015

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  X   AFDC intake interviews

       Other outreach activities (specify):

       Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	0%	99%
Health Department	100%	1%
Comprehensive Providers	0%	0%
Other (specify)		

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Active provider recruitment is not carried out. Usually the provider requests a packet and a number so recipients may be cared for in his practice.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*North Dakota's original EPSDT program design was determined cooperatively by the States physicians (including the pediatricians), dentists, other health professionals, and State personnel. The final decision was to utilize existing public health facilities and nurses under agreement for all the screening activity with all referrals for diagnosis and treatment made to private providers of the recipients choice.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>          </u>	Automated?	<u>     X     </u>	Both?
<u>          </u>	Manual?	<u>     X     </u>	Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*The screening input document is being revised to capture the date services were requested.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*The area EPSDT coordinators attend formal quarterly meetings. The most recent program was presented by the Minot Speech and Hearing Center. The coordinator conducts county personnel training sessions. The screening nurses attend at least two formal State sponsored workshops annually. One of the State level workshops is presented by the State EPSDT coordinator.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*Service delivery: Our program has screening provided by Public Health nurses (RN's). The screenings take approximately 45 minutes per person and are very thorough. Major emphasis is placed on health teaching during the assessment.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*The agency has agreements with the Title V programs and the Head Start programs across the State. The linkages facilitate informational exchange and eliminate screening duplication.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*None*

STATE: Ohio

C

REGION: V

STATE EPSDT COORDINATOR:

NAME: Ms. Colleen McMurray  
TITLE: Chief, Bureau of EPSDT  
AGENCY: Division of Medical Assistance  
ADDRESS: Ohio Department of Public Welfare  
State Office Tower, 31st Floor  
30 E. Broad Street  
Columbus, Ohio 43215  
PHONE: 614-466-5748  
FTS 942-5748

1. AGENCY ADMINISTERING EPSDT IS: Social Services/Welfare

2. PROGRAM IS: State Supervised/County Administered

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 474,000 AFDC

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

X AFDC intake interviews For newly eligibles only

X Other outreach activities (specify): For non-participating group.  
They are informed by income maintenance worker and program persons  
in the home or office, depending on the county.

       Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	65%	65%
Health Department	20%	20%
Comprehensive Providers		
Other (specify) Pediatric Groups, Free Standing Clinics	15%	15%

Providers must give all services. All Medicaid Title XIX providers are eligible to be EPSDT providers. Private physicians, health departments are used by most clients, others use pediatric groups and free standing clinics.

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*By local staff and coordinator in each county. If problems with policy or reimbursement, administration becomes involved. Recruitment is done on a 1-1 basis. All Title XIX providers are eligible.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Original was done with all provider type groups involved. The EPSDT advisory committee meets quarterly to make decisions on problems.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>  X  </u>	Automated?	<u>      </u>	Both?
<u>  X  </u>	Manual?	<u>  X  </u>	Linked to MMIS?

*The automated part is linked to MMIS.*

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Yes, had planned when GSD was approved. Now waiting to see what the Federal Government is going to do.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Use a training package. Annual training activity for local staff and provider staff. Once each quarter train new staff. Bring in other regional and State staff on a quarterly basis to keep them informed of changes.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

Local County Welfare staff is used rather than purchasing outreach services. It works well. Outreach and case management is viewed as a social service program and it is important to identify with clients on a 1-1 basis.

Printouts that are used list all identifying information on children and reveals the services received which in turn provides data for tracking. The printouts are mailed to each county each month. The printouts identifies duplication and makes known current health activities on each child.

This procedure is also used in dental hygiene. The State also developed a model curriculum to assist non-program people.

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*The State has existing agreements with Title V agencies and with SSI children. The focus is on coordination of services and avoiding duplication of services.*

*They have begun discussions with the Department of Education, Department of Mental Health, Mental Retardation, Developmental Health, Ohio Rehabilitation Center, Environmental Health, HUD, and the State Economic and Community Development Agency for support services.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*No plans for contracts*

STATE: Oklahoma

REGION: VI

STATE EPSDT COORDINATOR:

NAME: Bertha M. Levy, M.D.

TITLE: Supervisor, Medical Services Division

AGENCY: Department of Human Services

ADDRESS: P. O. Box 53124

Oklahoma City, Oklahoma 73152

PHONE: 405-521-3801

1. AGENCY ADMINISTERING EPSDT IS: Social Service/Welfare

2. PROGRAM IS: State Administered

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 172,182

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  X   AFDC intake interviews

  X   Other outreach activities (specify): Explicit offer of services is made during a home visit which is made to complete the certification process. Workers have combined assistance payments and social service responsibilities.

  X   Other: Annual mailing to non-participating families on anniversary of certification date, except for illiterate and non-English speaking families where a list is prepared for contact by workers.

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	100%	100%
Health Department		
Comprehensive Providers		
Other (specify)		

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Participation in the Medicaid program is open to all licensed physicians and 97 percent currently participate.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Medicaid has a very active medical advisory committee which advises the EPSDT program as well. Many providers have been active in the program since implementation of the first Kerr-Mills bill.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>  X  </u> Automated?	<u>      </u> Both?
<u>      </u> Manual?	<u>  X  </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*No*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*One section of the Department has responsibility for staff development programs. Orientation and training is conducted for new employees and on a continuing basis.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

An automated case management system has been developed which is an integral part of MMIS. A full description of the program is planned for HCFA Perspectives. The system focuses on completing the assessment/treatment cycle in a short period due to rapid turnover in eligibility. The system also specifically identifies illiterate and non-English speaking families for special contact. Crippled Children's Services (CCS) is administered by the same department and has always been closely related to EPSDT. Much of the success of EPSDT is due to the 25 years of experience with CCS. The EPSDT program offers very broad coverage which reflects the association with CCS.

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*There are very close linkages to CCS because it is in the same agency and uses the same providers. A separate specific agreement with Head Start provides for offering EPSDT services. A general agreement is in place with the Health Department and other State agencies for cooperation and provides for referrals to EPSDT from all sources.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*None*

STATE: Oregon

REGION: X

STATE EPSDT COORDINATOR:

NAME: Mr. Paul Boughton  
TITLE: Adult Family Services Division  
AGENCY: Health and Social Services Section  
ADDRESS: Medichex Subunit  
203 Public Services Building  
Salem, Oregon 97310  
PHONE: 503-378-2762  
FTS 530-2762

1. AGENCY ADMINISTERING EPSDT IS: Umbrella
2. PROGRAM IS: State Administered
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 60,000
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  X   AFDC intake interviews

       Other outreach activities (specify):

       Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	100%	100%
Health Department		
Comprehensive Providers		
Other (specify)		

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*No active recruitment program. Recruitment and retention through adequate reimbursement liaison with medical associations. Good access everywhere.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Relevant associations are involved in the entire program.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>  X  </u>	Automated?	<u>      </u>	Both?
<u>      </u>	Manual?	<u>      </u>	Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*MMIS is expected to be implemented in spring of 1982.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*There is an active program of staff development and training. The director makes on-site visits to counties at least once a year. The EPSDT manual has recently been updated.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*State program is very effective, relative to what it costs the State.*

*Good local interagency collaboration.*

*The State has had problems monitoring collaborative efforts due to the attitudes of the Westinghouse/Head Start Program Coordinators. They are hesitant to share information at the State level.*

11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*Collaborative arrangements with county health providers.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*Agreements with some clinics to do the screenings, CCS and University of Oregon Health Sciences Center.*

STATE: *Pennsylvania*

REGION: *III*

STATE EPSDT COORDINATOR:

NAME: *Mr. James McKittrick*  
TITLE: *Division of Exceptional Reimbursement*  
AGENCY: *State Department of Public Welfare, Office of Medical Assistance*  
ADDRESS: *Health and Welfare Building, Room 505*  
*Harrisburg, Pennsylvania 17120* PHONE: *717-787-1171*  
*FTS 8-637-1171*

1. AGENCY ADMINISTERING EPSDT IS: *Social Service/Welfare*

2. PROGRAM IS: *State Administered*

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *514,000 (approx.)*

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  *X*   AFDC intake interviews

       Other outreach activities (specify):

  *X*   Other: *Re-determinations and encourage providers to inform.*

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	65%	65%
Health Department	7%	1%
Comprehensive Providers	23%	34%
Other (specify): <i>School Health,</i>	5%	
<i>Family Planning, Rural Health</i>		

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Via administrative contractors who call on providers individually.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*We had an advisory committee to the welfare secretary for the package of screens, the fee and the forms design.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>          </u>	Automated?	<u>      X      </u>	Both?
<u>          </u>	Manual?	<u>      X      </u>	Linked to MMIS? <i>(still to be debugged)</i>

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*In about 1½ years, client information system will be completely automated.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*No formalized program. Counties train workers - EPSDT is part of overall worker training.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

- 1) *Program Design - One universal package and billing and information form.*
- 2) *Case Management - Semi automated since 1973; fully automated soon.*
- 3) *Service Delivery - Provider recruitment quality control.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

1) *Local housing authorities (outreach, mobile site selection).*

2) *Health Department - screening.*

3) *Head Start, Day care - outreach.*

4) *Philadelphia School System - screening.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*Philadelphia Health Management Corporation - provider recruitment,  
quality control data management.*

*Rosetta Smith 215-629-8237*

*Automated Health Systems - provider recruitment, quality control  
data management.*

*Robert Doran 412-367-3030*

STATE: Rhode Island

REGION: I

STATE EPSDT COORDINATOR:

NAME: Mr. Donald Sullivan

TITLE:

AGENCY: Social and Rehabilitation Services

ADDRESS: 67 New London Avenue

Cranston, Rhode Island 02920

PHONE: 401-464-2181

1. AGENCY ADMINISTERING EPSDT IS: *Ubrella*
2. PROGRAM IS: *State Administered*
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *39,000*
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

\_\_\_\_\_ AFDC intake interviews

  X   Other outreach activities (specify): *Once eligibility has been determined, caseworkers visit families at their home and inform them of the EPSDT program as well as doing a social service assessment*

\_\_\_\_\_ Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	75%	75%
Health Department	18%	18%
Comprehensive Providers		
Other (specify): <i>RHIP</i>	2%	2%

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

- 1) Providers were consulted in developing form used and the periodicity schedule and this gives greater acceptance to the program.
- 2) Providers can contact State Coordinator with problems and policy questions and answers and solutions are provided quickly.
- 3) The reimbursement rate is higher for an EPSDT screen than for a medical assistance office visit.

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Providers were consulted in developing the form used for EPSDT and the periodicity schedule.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u> Automated?	<u>      </u> Both?
<u>  X  </u> Manual?	<u>      </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Changes depend upon the extent of State budget cuts.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*There is an ongoing refresher course. New employees are given training depending upon job history and the job for which they are employed.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*The EPSDT program in Rhode Island is centrally administered, which is possible because of the size of the State. Title XIX and Title XV are located in the same umbrella agency and the Department has a strong commitment to the program. It is Title XX workers who do the informing and are trained in providing social services. This enables the State to do more than many States.*

*The small size of the State also allows problems to be handled centrally. There is one answer and one interpretation of policy rather than ten, and questions are answered quickly. This is a great benefit to providers and recipients.*

*The relationship with the pediatric community is excellent which results in substantial benefits to the program.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*Title XV - outreach and follow-up*

*Title V - referral and follow-up*

*Department of Education - This is an informal linkage on an individual basis through local workers.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*None*

STATE: *South Carolina*

REGION: *IV*

STATE EPSDT COORDINATOR:

NAME: *Ms. Bonnie Witherspoon*

TITLE: *Director, EPSDT*

AGENCY: *Department of Social Services*

ADDRESS: *P. O. Box 1520*

*Columbia, South Carolina 29209*

PHONE: *803-758-3933*

1. AGENCY ADMINISTERING EPSDT IS: *Social Service/Welfare*

2. PROGRAM IS: *State Supervised/County Administered*

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *234,325*

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  *X*   AFDC intake interviews

       Other outreach activities (specify):

  *X*   Other: *Through computer support.*

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	6%	85%
Health Department	90%	
Comprehensive Providers	1%	
Other (specify) <i>Medical Universities</i>	1%	15%
<i>Schools</i>	1%	
<i>Rural Health</i>	1%	

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Primarily through the professional associations, county office staff, and State office provider relations staff. We attempt to provide individual attention if problems arise. We also consider provider in terms of procedural development and paper flow.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Initially, Department of Health was primary source. As program developed, all professional associations were included to include a pediatric (ad hoc) advisory committee as well as an in-house joint dental committee. The State Medical Care Advisory committee is also used.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>  X  </u> Automated?	<u>      </u> Both?
<u>      </u> Manual?	<u>  X  </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Privately undergoing major revision to integrate with MMIS. First phase July 1981; expected completion January 1982.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*We conduct technical assistance sessions for all county staff on a quarterly basis. Individual program monitors provide training on an individual county basis as requested.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*In 1973 developed a 6-part SD&T form which has worked well.*

*Developed a 1720 control card which condensed the documentation requirement of the casemanager.*

*Staffed field monitors with assigned counties to conduct program review, compliance monitoring, and technical assistance.*

*Provided local staff with preprinted screening forms and data reports.*

*Use professional consultants and associations to encourage provider participation.*

*Monitor regional participation by provider type and when needs are identified request assistance from local associations as well as county directors.*

*Contract with school district encompassing an entire county as pilot for the State.*

*Began to reimburse volunteers for providing transportation which removed some of that burden for the casemanager.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

### Interagency Agreement

1. Title V - screening and continuity of care.
2. Head Start - screening and information exchange.
3. Commission for the Blind - screening and information exchange.
4. Vocational Rehabilitation - screening, coordination, and information exchange.
5. Health Lead Screening Project - coordination of services.
6. HUD - coordination of benefits.
7. South Carolina Department of Education - screening, information exchange, and referral.
8. Juvenile Placement and Aftercare - service delivery and coordination.
9. Title XX - coordination of benefits.

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

### Contracts for Screening

1. Physicians
2. Health Department
3. Comprehensive Health
4. Rural Health
5. Outpatient Hospital
6. School System

Contracts for D&T exist with all other agencies and private provider types qualified to provide services covered in the State plan.

Dental contracts exist with local health departments, as well as several comprehensive health centers. Contracted with State Crippled Children's Division for the control and provision of hearing aids.

Presently developing a prudent buyer contract for the provision of glasses.

STATE: *South Dakota*

REGION: *VIII*

STATE EPSDT COORDINATOR:

NAME: *Ms. Sue Johnson*

TITLE: *Department of Social Services*

AGENCY: *Medical Services Administration*

ADDRESS: *Richard F. Kneip Building*

*Illinois Street*

PHONE: *605-773-3495*

*Pierre, South Dakota 57501*

1. AGENCY ADMINISTERING EPSDT IS: *Social Service/Welfare*

2. PROGRAM IS: *State Administered*

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *14,853*

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  X   AFDC intake interviews *face to face.*

  X   Other outreach activities (specify): *at review every 6 months.*

  X   Other: *annual letter.*

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	<i>100%</i>	<i>100%</i>
Health Department		
Comprehensive Providers		
Other (specify)		

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Pediatricians have done recruitment through Pediatric Association.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Medically - pediatricians wrote first provider manual and have worked on the revision. Dental Society has had direct input.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u>	Automated?	<u>  X  </u>	Both?
<u>      </u>	Manual?	<u>      </u>	Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*There will be a link to MMIS once system becomes certified.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Manuals are reviewed with new eligibility workers. This training is the responsibility of the eligibility supervisor in the local office.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*Informing has worked very well. One hundred (100) percent are being informed. Response rate is quite high.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*Good communication with Maternal & Child Health, Crippled Children, and other health department programs. However, all screens must be done by physicians.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*No formal contracts.*

STATE: *Tennessee*

REGION: *IV*

STATE EPSDT COORDINATOR:

NAME: *Mr. Robert Butler*

TITLE: *Bureau of Medical Administration and Coordination*

AGENCY: *Division of Medical Services*

ADDRESS: *283 Plus Park Boulevard*  
*Nashville, Tennessee 37219*

PHONE: *615-741-6372*  
*FTS 853-6372*

1. AGENCY ADMINISTERING EPSDT IS: *Health*
2. PROGRAM IS: *State Administered*
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *160,000*
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  *X*   AFDC intake interviews

  *X*   Other outreach activities (specify): *Hand outs*

  *X*   Other: *Mail outs, outreach letters*

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	<i>10%</i>	<i>30%</i>
Health Department	<i>88%</i>	<i>70%</i>
Comprehensive Providers	<i>2%</i>	
Other (specify)		

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Primarily by working through professional organizations throughout the State.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Considerable input initially and continuous input on an advisory basis. Use as trouble shooters.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>  X  </u> Automated?	<u>      </u> Both?
<u>      </u> Manual?	<u>  X  </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*None at this time unless Federal requirements change.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Update meetings occasionally. PHD's have continuous updating.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*Tennessee has an automated outreach system which is very effective and contributes materially to the success of the program.*

*Overall automation of the system permits claims form information flow from providers to the State agency in a cost and time effective manner.*

*There is a lack of sufficient providers in some rural areas.*

*State has provided other States with guidance in automated outreach system.*

11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*Good relationship with State professional societies. An example is Tennessee Dental Association.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*Contracts with Department of Human Services - does eligibility certification.*

*Interagency agreements - Title V, Title XX, Vocational Rehabilitation, Speech & Hearing, MCH, and CCS.*

STATE: Texas

REGION: VI

STATE EPSDT COORDINATOR:

NAME: Ms. Bridget Cook

TITLE: EPSDT Program Director

AGENCY: Texas Department of Human Resources

ADDRESS: P. O. Box 2960

Austin, Texas 78769

PHONE: 515-835-0440 (ext. 2644)

1. AGENCY ADMINISTERING EPSDT IS: *Umbrella*

2. PROGRAM IS: *State Administered*

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *265,000*

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  X   AFDC intake interviews, also recertification.

  X   Other outreach activities (specify): *Field staff is responsible for outreach/support services on a continuing basis.*

  X   Other: *Monthly lists by family unit of eligibles due for rescreen or dental referral. Weekly lists of new and recertified eligibles. Monthly lists of all EPSDT eligibles with screen date.*

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians		<i>Health Department formerly provided 100% of</i>
Health Department		<i>medical screening assessments under contract,</i>
Comprehensive Providers		<i>but program is now using an expanded provider</i>
Other (specify)		<i>base, e.g., private physicians, clinics, home</i>
		<i>health agencies, school districts, etc. A</i>
		<i>full range of providers is used for diagnosis</i>
		<i>and treatment services. Dental screening,</i>
		<i>diagnosis, and treatment is a one step process</i>
		<i>using private provider base and selected clinics.</i>

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*See number 10.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*A separate dental advisory committee of seven members representing various professional groups provides input and assists in explaining program changes to providers. An ad hoc committee of the Medical Care Advisory Committee is assisting with medical screening policies and procedures. An advisory committee for Family Self-Support Services is used for general program matters. Program staff maintains close relationships with the Texas Medical Association and other associations.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>  X  </u> Automated?	<u>      </u> Both?
<u>      </u> Manual?	<u>  X  </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Subsystem of MMIS tracks through screening. New procedures for tracking for diagnosis and treatment are being developed due to a change to integrated social service workers in the field including health related programs, family planning, and employment.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Department has formal programs, and program conducts sessions with field staff as needed.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

Provider Recruitment and Retention:

- A. Dental. Four Field Coordinators work with the dental provider base. They call on providers to furnish more information, explain program policy, and deal with provider problems. They assist in recruitment efforts in shortage areas. The coordinators also participate in utilization review and control.

Dental providers use toll free telephone lines for questions and receive same day response. Questions pertain principally to authorization and payment, but a wide variety of questions come in.

The Coordinators have broad responsibility; and due to their effectiveness, there is an adequate stable dental provider base that supports the program. Dental groups provide consultation on program policy.

- B. Medical. Since termination of the Health Department medical screening contract, the program enrolled 850 physicians. Currently, 350 are participating. To broaden the participating provider base, an ad hoc committee of the Medical Care Advisory Committee and liaison with the Texas Medical Association has been established. This group is conducting a complete review of the program policies and procedures with participation by several specialty groups. After making recommendations for changes in procedures and policies, the group will assist in physician recruitment.

A questionnaire will be distributed to each participating physician about existing policies and procedures. A toll free telephone line for medical screening providers will be established. Newly licensed physicians will be contacted on a continuing basis. The program plans to integrate EPSDT screens into annual family planning examinations. The medical I.D. card, issued monthly, will indicate eligibility for periodic medical and dental screening by a "yes" or "no".

Dental Utilization Review: On a random sample basis, a dental team (dentist and dental assistant) is sent to review cases in the field. The team evaluates records and conducts patient examinations to detect fraud, abuse, and monitor the quality of dental care. The number of discrepancies has dropped significantly.

Outreach: The field staff receives weekly lists of newly certified and recertified cases and monthly lists of eligibles due for rescreening or dental referral under the periodicity schedule. Face-to-face informing occurs at intake, but subsequent tracking for screening is the responsibility of the new generic Family Self Support Services worker who also arranges for support services, i.e., transportation and scheduling. Three specialized lists of eligibles are produced as described under number 4.

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*Health Department makes necessary vaccines available to all screening providers at no cost.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*Title V arranges for all hearing aids, including audiological testing.*

*In some selected areas, the Health Department still conducts screenings.*

*In San Antonio and Houston, outreach and support services are provided through contractual arrangements with local organizations.*

*Commission for the Blind provides visual services. Texas Education Commission arranges for excused absences for screening purposes.*

*An agreement with the Health Department in one region provides for dental services using a mobile van. The underserved area serviced by the van includes 11 counties.*

*The Health Department by contract provides all laboratory services for medical screens. The procedures have proven very effective from the provider viewpoint because the laboratory furnishes all materials and equipment; free mailers; sends accurate, timely results; and makes phone calls to providers when needed. The program benefits from lower costs of approximately \$5 per battery of tests, depending on screening volume. The laboratory sends equipment and materials to new providers as they enroll.*

STATE: *Utah*

REGION: *VIII*

STATE EPSDT COORDINATOR:

NAME: *Margie D. Denison*  
TITLE: *Administrative Coordinator*  
AGENCY: *Utah State Department of Health*  
ADDRESS: *44 Medical Drive*  
*Salt Lake City, Utah 84113* PHONE: *801-533-6455*

1. AGENCY ADMINISTERING EPSDT IS: *Health*
2. PROGRAM IS: *State Administered*
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *31,997*
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  *X*   AFDC intake interviews

       Other outreach activities (specify):

  *X*   Other: letter, telephone, and/or home visit contact with new eligible families. Also, via community organizations.

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	75.4%	80%
Health Department	13.4%	0%
Comprehensive Providers	11.2%	20%
Other (specify)		



6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*There is a provider relations section in the Division of HCF. Also local EPSDT specialists contact providers to sell program, handle problems, etc.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Utah State Medical and Dental Association have had input into early program planning. Also there are medical and dental representatives on the Medicaid Medical Sub-committee.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u> Automated?	<u>  X  </u> Both?
<u>      </u> Manual?	<u>      </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Changes are planned. Two consultant firms, one looking at only EPSDT subsystem and one studying the entire MMIS have been in during the past year. Date for implementation is unknown.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*There is a planned program for orienting new employees. Staff meet quarterly for development programs.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



## 10. (Continuation Sheet for Description of Effective Practices).

*In 1979 EPSDT was transferred from Social Services to Health Department, and is now located in the Division of Family Health Services which administers Title V programs. This has facilitated better coordination of child health programs.*

*There continues to be good cooperation between Health and Social Services, however Social Services continues to provide outreach and case management of foster care and eligible day care kids.*

*The State Health Department has EPSDT specialists located in district/county health departments who do outreach, followup and case management. They coordinate with clients, providers, assistance payments offices and social services on the local level.*

*Providers are becoming better informed about the program through the efforts of the EPSDT specialists and provider relations. Clients have free choice of provider, i.e., private physicians, health department, clinic or HMO.*

*Screenings have increased from 8,000 last fiscal year to 7,400 for seven months of this year.*

*Advantages of our State environment:*

- 1) Utah is a family oriented State. Much emphasize is placed on the family unit and parents being responsible for the care of their children.*
- 2) The predominant religion of the State believes in a healthful life style which includes healthy diet, abstinence from tobacco, alcohol, tea, coffee, etc.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*There is an agreement between the Division of Family Health Services which administers EPSDT and the Division of HCF, the Medicaid Agency. Both divisions are in Health Department.*

*Agreement between Health and Social Services in areas of informing at intake and case management of foster care and day care.*

*Agreement between EPSDT and Head Start Title XIX and Title V.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*Contracts with:*

- 1) Family Health Plan (HMO) - screening, diagnosis and treatment.*
- 2) Delta Plan - Fiscal agent for dental program administration and claim processing.*

STATE: Vermont

REGION: I

STATE EPSDT COORDINATOR:

NAME: Joy Morrell  
TITLE: Director of Health Services Field Operations  
AGENCY: Department of Health  
ADDRESS: 115 Colchester Avenue  
Burlington, Vermont 05401  
PHONE: 802-862-5701 (ext. 365)

1. AGENCY ADMINISTERING EPSDT IS: Social Service/Welfare

2. PROGRAM IS: State Administered

3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 25,000

4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  X   AFDC intake interviews

  X   Other outreach activities (specify): Direct face-to-face with an  
EPSDT worker.

  X   Other: WIC programs, schools, well child clinics, Title I programs,  
day care center, Head Start.

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXI-  
MATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	98%	98%
Health Department	1%	1%
Comprehensive Providers	1%	1%
Other (specify)		

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*AAP - Vermont Chapter, 100% participation without contracts.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*AAP - Vermont Chapter, annual visit. Quarterly chapter meetings.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u> Automated?	<u>      </u> Both?
<u>  X  </u> Manual?	<u>      </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*No, will remain manual.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Yes, but integrated with other health systems. There are no assigned personnel to EPSDT.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*Comprehensive Approach: Integration with all health providers; WIC, Handicapped Children's Program, etc. The approach is not only a screening but a full assessment of the child's needs with a preventive/educational concept involved. All aspects covered in the home interview. Forwarded to the physician.*

*Health program representative makes the offer of all services available including support. The representative serves as the link between the client and the medical/dental provider and other agencies.*

*Expertise lies in the integration of maternal and child health programs.*

11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*Title V and Crippled Childrens, WIC, Immunizations, SIDS-Sudden Infant Death Syndrome, Special Education.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*None*

STATE: Virginia

REGION: III

STATE EPSDT COORDINATOR:

NAME: Mrs. Vickie Simmons  
TITLE: Virginia Medical Assistance Program  
AGENCY: State Department of Health  
ADDRESS: 109 Governor Street, 8th Floor  
Richmond, Virginia 23219

PHONE: 804-786-6273  
FTS 8-936-6273

1. AGENCY ADMINISTERING EPSDT IS: Health
2. PROGRAM IS: State Supervised/County Administered
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 144,806
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  X   AFDC intake interviews

  X   Other outreach activities (specify): Local Health Department  
does informing but not documentation.

  X   Other: SSI program for disabled children.

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

Virginia has no enrollment of partial  
service providers.

Physicians  
Health Department (local)  
Comprehensive Providers  
Other (specify)

<u>SCREENING</u>	<u>AND</u>	<u>DIAGNOSIS AND TREATMENT</u>
		700
		134
		(Percentage breakdown unavailable)

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*A memo was sent to all primary care providers for the initial enrollment effort in 10/79. Currently, as new physicians contact Medicaid to enroll, if they have the appropriate specialty, they are automatically sent EPSDT enrollment packages.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*The Child Health Advisory Committee assisted State Health in modifying American Academy of Pediatrics schedule of periodicity.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>  X  </u> Automated?	<u>      </u> Both?
<u>      </u> Manual?	<u>  X  </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Changes planned are to phase out manual tracking. Changes to automated system not anticipated, but would be dependent upon changes in Federal regulations.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*There is no ongoing training program. Health departments' coordinator works with private physicians and local health departments and welfare department coordinator works with local welfare offices.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*Both Medicaid and local health departments are part of the Virginia State Department of Health. Being "first cousins" within the same agency makes it easy to develop common goals and a highly cooperative atmosphere. Local health departments perform 50-60% of the volume of screening.*

*Since October, 1979, Medicaid screening has been available for participation by the private sector.*

*The Health Department has an agreement with State Welfare Department to provide outreach services. State Welfare, through its local welfare agencies, performs informing and followup for delinquency.*

*Virginia's EPSDT case management system has just recently become totally operational. It has all the basics of HCFA's GSD with slight variations which make it more helpful to Virginia and her recipients. The system is essentially one which offers the capability of local case management in addition to Federal reporting requirements.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*The Title XIX agency and the State Health Department (SHD) has an interagency agreement with the State Welfare Department (SWD) to share EPSDT "tasks." Generally, the SWD through its local welfare agencies is responsible for informing, scheduling assistance, obtaining transportation assistance and followup with delinquent appointments for private providers. The SHD through its local health departments provides screening and treatment services and followup on its own delinquencies. SHD through its Medicaid program reimburses all providers of EPSDT services.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*Medicaid (within SHD) has a fixed fee schedule of reimbursement with local health departments (within SHD). This is a negotiated rate.*

*The contract that SHD has with SWD with regard to EPSDT services is being examined by the SWD.*

STATE: *Washington*

REGION: *X*

STATE EPSDT COORDINATOR:

NAME: *Ms. Lee Talmadge*  
TITLE: *Office of Medical Assistance*  
AGENCY: *Health Services Division LK-11*  
ADDRESS: *Department of Social & Health Services*  
*Olympia, Washington 98504* PHONE: *206-753-7313*

1. AGENCY ADMINISTERING EPSDT IS: *Umbrella*
2. PROGRAM IS: *State Administered*
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *133,200*
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  *X*   AFDC intake interviews

       Other outreach activities (specify):

       Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

Physicians  
Health Department  
Comprehensive Providers  
Other (specify)

SCREENING

DIAGNOSIS AND  
TREATMENT

*Currently unavailable*

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Any Medicaid physician with a Medicaid number may provide EPSDT screening. The screening must conform to guidelines. Providing clinics have contracts. State has good reimbursement rates, with fast and simple billing*

*State has good reimbursement rates, with fast and simple billing.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Medical Care Advisory Committee works with medical organization in all programs.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u> Automated?	<u>      </u> Both?
<u>      </u> Manual?	<u>  X'  </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*No major changes planned, but EPSDT now limited to catagorically needy.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Initial training for EPSDT caseworkers.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*Take a rational approach to health planning and resource utilization.*

11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*Informal working relationships with other agencies.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*Titles V & XIX - 2 or 3 years old*

STATE: *West Virginia*

REGION: *II*

STATE EPSDT COORDINATOR:

NAME: *Mr. John Boles*

TITLE: *Division of Medical Care*

AGENCY: *State Department of Welfare*

ADDRESS: *1900 East Washington Street*

*Charleston, West Virginia 25305*

PHONE: *304-348-8990*

*FTS 885-8990*

1. AGENCY ADMINISTERING EPSDT IS: *Social Service/Welfare*
2. PROGRAM IS: *State Administered*
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *Approximately 59,000*
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  X   AFDC intake interviews

  X   Other outreach activities (specify): *Health does a second follow-up outreach with more depth.*

       Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians ( <i>Private</i> )	<i>0%</i>	<i>70%</i>
Health Department	<i>100%</i>	<i>30%</i>
Comprehensive Providers		
Other (specify)		

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*The providers are the two medical health departments. They set up agreements with other groups who are interested providers. These are generally county or community health centers.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*The pediatric community has been the major contributor. Private physicians, the four medical school pediatric chairpersons, were included as well as the Health Department Directors who are major providers.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u>	Automated?	<u>  X  </u>	Both?
<u>      </u>	Manual?	<u>      </u>	Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*West Virginia is moving to full automation before the end of 1981.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*The formalized staff development and training is generally left to the local unit providers beyond the initial orientation.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*West Virginia is in the process of reevaluating all aspects of the EPSDT program. It would seem counterproductive to comment since we anticipate major changes within the next 6 months.*

11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*West Virginia Department of Health has an agreement to provide informing, screening, and some diagnosis and treatment. We plan an expansion of diagnosis and treatment follow-up services to assure greater quality.*

*West Virginia Southern Regional Health Council has an agreement to do screening.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*None*

STATE: Wisconsin

REGION: V

STATE EPSDT COORDINATOR:

NAME: Mr. Charles Trevallee  
TITLE: Bureau of Health Care Financing  
AGENCY: Department of Health and Social Services  
ADDRESS: 1 West Wilson Street, Room 290  
Madison, Wisconsin 53702  
PHONE: 608-266-5332  
FTS 366-5332

1. AGENCY ADMINISTERING EPSDT IS: *Umbrella*
2. PROGRAM IS: *State Administered*
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: *187,923*
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

  X   AFDC intake interviews

  X   Other outreach activities (specify): *The fiscal intermediary produces a list of all eligibles, a list of all eligibles who have participated and a list of those who have never participated. Contracted outreach agencies handled outreach through face to face in the home.*

       Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	5%	99%
Health Department Comprehensive Providers	85%	
Other (specify) <i>Non-physician Screeners and Community Health Centers</i>	10%	1%

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Began enrolling private physicians in December, 1980. A brochure was mailed to all potential providers with a return postcard. Currently have enrolled 500 private physicians.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*Technical Advisory Committee of the State Medical Society have been involved in all phases of program design: provider recruitment, periodicity, etc.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u> Automated?	<u>  X  </u> Both?
<u>      </u> Manual?	<u>  X  </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*None at this time.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*Two annual workshops. First is conducted by State Central Office staff. Second workshop consisted of formal training given by outreach and screening providers. Quarterly training meetings with the eight State districts is conducted by contractors and State health trainers.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

1. *Increased screening participation is related to incentive rates to outreach contractors. Incentive rates ranged from \$10 for unsuccessful outreach to \$20 for successful outreach. Additional incentives were given for medical and dental referrals. Incentives were effective but extremely costly. Contracts for outreach have now been terminated in most cases. There is a possibility of new contracting on a greatly reduced level.*
2. *Outreach and screening agency input in training planning and presentation has been very effective. Annual conference reached approximately 300 people.*

11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*None*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*Agreement with Economic Assistance to provide informing at intake. There are State agreements with MCH and WIC agencies regarding the EPSDT program. State agreement with Head Start is in effect. Outreach contractors must have local agreement with Title V on the local level. Examples of these agreements are provided in the EPSDT-Outreach Manual and are detailed in the contract.*

STATE: Wyoming

REGION: VIII

STATE EPSDT COORDINATOR:

NAME: Ms. Maureen Maier  
TITLE: Medical Assistance Services  
AGENCY: Division of Health and Medical Services  
ADDRESS: Department of Health and Social Services  
Hathaway State Office Building PHONE: 307-777-7531  
Cheyenne, Wyoming 82002

1. AGENCY ADMINISTERING EPSDT IS: Health
2. PROGRAM IS: State Supervised/County Administered
3. NUMBER OF MEDICAID ELIGIBLES UNDER 21: 4,299
4. ELIGIBLE CHILDREN ARE INFORMED THROUGH (CHECK):

☒ AFDC intake interviews

☐ Other outreach activities (specify):

☐ Other:

5. WHAT IS THE PROVIDER MIX, BY TYPE OF SERVICE? (PLEASE SHOW APPROXIMATE PERCENTAGE.)

	<u>SCREENING</u>	<u>DIAGNOSIS AND TREATMENT</u>
Physicians	100%	100%
Health Department		
Comprehensive Providers		
Other (specify)		

6. HOW IS PROVIDER RECRUITMENT AND RETENTION ACCOMPLISHED?

*Informed at annual licensing. If they are interested in participating, they enter into a general Medicaid contract.*

7. WHAT IS/WAS THE INPUT OF STATE/LOCAL MEDICAL/DENTAL COMMUNITY INTO EPSDT PROGRAM (RE)DESIGN? DESCRIBE:

*An Advisory Board and a Resident Physician who is a pediatrician provide input into the program design.*

8. IS THE CASE TRACKING/INFORMATION SYSTEM NOW:

<u>      </u> Automated?	<u>      </u> Both?
<u>  X  </u> Manual?	<u>      </u> Linked to MMIS?

ARE CHANGES PLANNED? DESCRIBE AND GIVE PLANNED IMPLEMENTATION DATES:

*Title XX will be automated with MMIS. Claims processing may be automated. A plan is in the works.*

9. DESCRIBE FORMALIZED PROGRAM OF STAFF DEVELOPMENT AND TRAINING IF ANY:

*No formalized training. Staff development is done by the welfare component.*

10. DESCRIBE EPSDT PRACTICES IN YOUR STATE THAT YOU FEEL ARE ESPECIALLY EFFECTIVE OR CONTRIBUTE SUBSTANTIALLY TO THE RESPONSIVENESS OF THE PROGRAM TO CLIENT, PROVIDER, INTERNAL MANAGEMENT, AND REPORTING NEEDS. FOCUS ON THE FOLLOWING MAJOR AREAS:

Program (Re)design	Services Delivery
Outreach/Informing	(Screening, Diagnosis,
Case Management/MIS	and Treatment)

INCLUDE PARTICULAR ADVANTAGES TO YOUR STATE ENVIRONMENT, BARRIERS TO IMPLEMENTATION, IF ANY, AND HOW RESOLVED, AND ANY SPECIAL OPERATIONAL REQUIREMENTS. ALSO INDICATE YOUR AREAS OF EXPERTISE IN WHICH YOU CAN PROVIDE TECHNICAL ASSISTANCE TO OTHER STATE PROGRAMS.



10. (Continuation Sheet for Description of Effective Practices).

*Small eligible population allows for total case management.*

## 11. COLLABORATIVE EFFORTS/CONTRACTS

- A. What linkages or working relationships does the agency administering EPSDT have with other State/local agencies to assist in carrying out the program? Please describe the type of service(s) provided and name linkage agency(ies). Include linkages planned but not completed.

*There are working relationships with Title V, Child Development, and the Nursing Division of Public Health.*

- B. What contracts does the agency administering EPSDT have (or plan) with other public or private agencies or groups for provision of EPSDT outreach, clinical, or administrative services? Please describe type of service(s) provided and name (to be) contracted agency.

*There are formal contracts with Title V, but they are extremely old; mainly hand shake agreements.*

**APPENDIX B**

**HCFA MEDIA SERVICES**





## EPSDT TV SPOTS

## A WHODUNNIT GUIDE

Television advertising is one of the most powerful of the communication media for reaching and motivating large numbers of people quickly. Public agencies have long recognized the value of television exposure for their programs and have promoted visibility for the programs through various formats--news items, documentary and discussion programs, and brief public service announcements (PSAs or spots). Television stations seeking to satisfy Federal requirements for community service are often quite cooperative in providing occasional air time to broadcast public service announcements at no cost and even in some cases providing free assistance in the preparation of the announcements. Because competition for the viewer's attention is keen and because stations prefer to air the best quality announcements, professional producers have been utilized by some agencies with considerable success but at some expense.

The decision to produce television spots to promote the EPSDT program should be based on several considerations and be part of an overall promotional effort aimed at specific

objectives. Then spots can be targetted to the specific audience and the message developed that attracts and informs this audience. For example, is the the purpose to increase the overall number of persons seeking EPSDT examinations, or to increase the track record for certain age groups, ethnic groups, or the racial mix? The spots can be targetted to the specific audience desired and the message developed that best attracts and informs that audience. Consideration should be given to use of all media--radio, for example, may be more effective for some messages and groups, less expensive, and more accessible (broadcasters may use more of your material and more often) than television.

If your agency decides that television is a necessary part of your promotion campaign, you may be interested in the experience and materials, developed during recent State and Federal EPSDT promotional campaigns. Here are some producers of recent EPSDT television public service announcements:

ALASKA

Agency:  
Department of Health and  
Social Services  
Pouch H-01  
Juneau, Alaska 99811  
(907) 465-3030

The Alaska program produced two PSAs in 1978 and 1980 with a public television station. One focuses on scenes of children playing in the summer, the other in winter. The PSAs were spot as 60-second spots. and 30-second lifts were done from each.

Producer: KTOO-FM Radio, Juneau

For information contact:

Bill Collins  
Mail Stop 505  
Dept. HHS, Region X  
1321 2nd Avenue  
Seattle, Washington 98109  
(206) 442-0506

#### CALIFORNIA

Agency:

Los Angeles County Child Health  
and Disability Program (CHDP)

Last year this agency managed to obtain the services of the popular television actor, Lou Ferrigno, who plays The Incredible Hulk and who himself suffered from a childhood hearing impairment, to appear in and narrate a very effective 30-second PSA. The 30-second spot was produced commercially for the agency.

Producer: Bronson Films

Contact:

Jim Tarten  
Bronson Films  
1155 North Bronson Avenue  
Los Angeles, California 90038  
(213) 467-1609

Agency:

Bay Area Counties CHDP  
(Child Health & Disability  
Program)

In 1978, several counties jointly initiated the production of a 30-second PSA utilizing animation which illustrates the importance of periodicity in the screening program. After use in an intensive TV spot campaign in the S.F. area, the State CHDP program utilized it throughout California.

Producer: Bay Cities Public  
Relations

Contact:

Paul Von Beroldingen  
Bay Cities Public Relations  
241 7th Avenue  
San Francisco, California 94118  
(415) 751-1858

#### IOWA

Agency:

Iowa Dept. of Social Services

With permission from the Kansas City Regional Office, Iowa adapted an existing 60-second PSA featuring Willie Wilson of the Kansas City Royals baseball team. The closing segment, featuring two young children making the pitch for EPSDT, was produced uniquely for the Iowa version.

Producer: See Missouri producer

Contact:

Kathi Kellen

EPSDT Coordinator  
Iowa Dept. Social Services  
Hoover State Office Building  
5th Floor  
Des Moines, Iowa 503198  
(515) 281-8795

# MISSOURI

Agency:  
HHS Region VII Medicaid and  
Public Affairs Offices in Kansas  
City

60-second PSA featuring  
star-base-stealer Willie Wilson  
of the Kansas City Royals  
baseball team.

Producer: Dick Walt  
Region VII, OPA

Contact:  
Dick Walt  
Office of Public Affairs  
HHS, Region VII  
601 East 12th Street  
Kansas City, Missouri 64106  
(816) 374-2821

# TEXAS

Agency:  
HHS Region VI Medicaid Bureau

The agency enlisted the services  
of Dallas Cowboy footballer Tony  
Hill to star in the production of  
2 PSA's (1-60 and 1-30) on  
EPSDT. The spots were  
distributed throughout the State  
in late 1980 and are still in use.

Producer: KDFW-TV

Contact:  
Betty Collins  
EPSDT Coordinator  
HHS, Region VI  
1200 Main Tower Bldg., 24th Floor  
Dallas, Texas 75202  
(214) 729-6481

# WASHINGTON

Agency:  
Washington Dept. of Social &  
Health Services

In 1976, a multi-media campaign  
was developed for use throughout  
the State, with campaign  
materials including an animated  
TV PSA with Dr. EPSDT (a  
physician-kangaroo), coloring  
books, radio spots, posters,  
brochures, and four 16 mm. films.

Producer: Nyla M. Ford

Contact:  
Bill Collins  
Mail Stop 709  
Dept. HHS, Region X  
1321 2nd Avenue  
Seattle, Washington 98101  
(206) 442-0506

Agency:  
Washington Dept. of Social &  
Health Services

As part of a community-wide  
"Check-it-Out" campaign conducted  
in Seattle, HHS, Region X office  
developed a 60-second PSA  
featuring Bill Gregory of the  
Seattle Seahawks football team.



Producer: KING-TV, Seattle

Contact:

Bill Collins  
Mail Stop 709  
Dept. HHS, Region X  
1321 2nd Avenue  
Seattle, Washington 98101  
(206) 442-0506

D.C. CENTRAL OFFICE

Agency:

Social and Rehabilitation Service

From 1971-1977, SRS initiated the production of a half-dozen TV PSA's on EPSDT, including the following:

"Early Screening," produced by Wm. Greaves (NYC), stressing the early detection of problems with vision, hearing, and teeth (NOTE: English and Spanish versions distributed)

"Marathon," produced by Blackside, Inc. (Boston), showing how poor health can truly slow down children of all ages

"Juvenile Diabetes," produced by Wm. Greaves (NYC), based on an actual case history of a Tennessee youth whose condition was accidentally discovered while visiting the doctor for vision screening

"Basketball," produced by Blackside, Inc. (Boston), stressing the health screening needs of teenagers

"Football," produced by Wm. Greaves (NYC), depicting a group of youngsters having to bring a

halt to their touch football when one of the quarterbacks becomes dizzy and is encouraged by his peers to see a doctor  
"Infant Care," produced by SRS/OPA to stress the importance of the very first health screening available to any child--that provided by the hospital a few days after birth

Contact:

Dan O'Connor  
A/V Officer, HCFA  
HHH Bldg., Rm. 118-F  
200 Independence Ave., S.W.  
Washington, D.C. 20201  
(202) 245-6076

NOTE:

HCFA/OPA is currently planning the production of 3 new TV PSA's on EPSDT, as well as numerous radio PSA's on EPSDT in both English and Spanish. Before being distributed nationally, they will be tested for relative effectiveness in one or two cooperating States.

IDEAS AND ASSISTANCE

Some State and local programs have used prints of existing material and added their own tag lines with the agency name, address or telephone number. This can be done with some of the spots listed above.

In general, the contacts listed above can help staff in other programs to buy prints of their spots. They can also share



information about how the spots were made. The Health Care Financing Administration can also provide technical assistance and advice regarding production of television public service announcements.

Contact:

The Audiovisual Officer,  
Office of Public Affairs, HCFA  
Room 118F  
Hubert H. Humphrey Building,  
200 Independence Ave., S.W.  
Washington, D.C. 20001  
or Call 245-6076

NOTE: Persons wishing to use or adapt for use before a public audience any of the PSA's should get in touch with the contact person listed herein for the PSA involved.

Video - A tape of selected PSA's from those mentioned above is available from your HCFA Regional EPSDT Coordinator.



### REGULATION REVIEW

This section lists recent regulations published in the Federal Register of interest to Medicaid and Medicare managers.

### ACTION TRANSMITTALS/INFORMATION MEMORANDUMS

This section lists the new ATs and IMs that were published since the previous MMX was prepared.

### LEGISLATIVE LEDGER

The ledger summarizes important bills and laws that affect the Medicare and Medicaid programs.

Contact: Office of Legislation and Policy - (202) 426-3717

### PERSONNEL

Under this heading, the MMX lists personnel changes of top executives in Medicaid medical assistance units and single State agencies, Medicare intermediaries and carriers, and HCFA central and regional offices.

### BENEFICIARY SERVICES UPDATE

This column describes what is happening in the field of beneficiary services.

Contact: Office of Beneficiary Services - (301) 594-1659

### MMIS UPDATE

This section updates MMIS activities in the States.

This part of the MMX discusses the kinds of technical assistance M/MMI's Corrective Action Projects Division offers to the States. It also explains projects CAPD has underway or has completed in such areas as third party liability, data exchange, and error prone profiling/eligibility management.

CHILD HEALTH CHECKUP

This column describes State, regional and central office activities in the EPSDT program. It highlights State efforts in assuring that high quality health services are reaching poor children in need of such care.

Contact: Office of Standards and Performance Evaluation - (301) 594-4213

NOTES FROM THE OFFICE OF INTERGOVERNMENTAL AFFAIRS

This section includes significant activities in the Office of Intergovernmental Affairs.

Contact: Office of Intergovernmental Affairs - (301) 594-9725

LITIGATION IN BRIEF

In this section, important Medicaid and Medicare litigation cases are briefly outlined.

Contact: Bureau of Program Policy/Division of Technical Policy and Litigation - (301) 594-9756

MANAGEMENT ILLUSTRATED

Management Illustrated may be described as a "how-to-do-it" publication and may be used as a reference for States seeking more efficient and effective management methods which are transferable from State to State in the administration of the Medicaid program. The publication is essentially designed as a management practice exchange of successfully implemented innovative practices which have made a strong contribution to improving HCFA programs.

Management Illustrated promotes this exchange of ideas, skills, and techniques as well as the identification of unique accomplishments among States in areas such as long-term care, quality control, data/information systems, claims payment reviews, eligibility, EPSDT, utilization control or provider relations.



To support HCFA's goals for improving program management, it is important that the most valuable and worthwhile endeavors be published and disseminated to State Medicaid agencies and HCFA central and regional office staff.



**APPENDIX C**  
**SYNOPSIS OF SITE VISITS**





APPENDIX CSYNOPSIS OF SITE VISITS

During November and December 1980, site visits were conducted to assess the practices of several States. These States were identified by HCFA staff because they have noteworthy practices in particular components of the EPSDT Program: South Carolina for its information system capability; Idaho for its outreach and case tracking efforts; Missouri for its linkage with the Job Corps Program in the delivery of services; and finally, the health care prevention and promotion endeavors initiated in HCFA's Region X Office and tested in that Region's States. The following provides a synopsis of these site visits.

1. SOUTH CAROLINA

Several years ago, the South Carolina Department of Social Services developed, from a 1973 prototype, a multipart, computer generated form specifically for EPSDT. Known as the "green form," Form 1724 is computer generated at the State level from county lists of newly identified AFDC and Medicaid eligible children. In its early forms, Form 1724 contained blocks for screening results, required prior authorizations, treatment plan, some billing data, and the signature of the State Welfare Director at the completion of treatment. Thus, the form produced a nearly complete medical record on a single page. The "green form" has since evolved as a result of pressure from provider groups who wanted the form to more closely resemble standard forms used for non-EPSDT patients. State officials feel that the alterations of the form resulting from provider demands have made the form generally less useful to State and county program administrators, although the institution of ICD-9-CM diagnosis and CPT-4 treatment codes has been helpful. At this writing, Form 1724, shown as Exhibit C-I (1976 version) and Exhibit C-II (currently used version), is likely to be totally revised as South Carolina prepares to institute a Medicaid Management Information System (MMIS) which will incorporate functions of the "green form." Despite these upcoming changes, however, the "green form" has been a highly useful tool in South Carolina and constitutes an adaptable model for State EPSDT environments similar to South Carolina.

2. IDAHO

In many States, EPSDT outreach and case tracking are labor intensive, problematic activities. In Idaho, where the program is known as "Health Check," these activities are particularly difficult. Although the EPSDT population is quite small, clients are geographically scattered over great distances of formidable terrain. Yet outreach workers make home visits to virtually all newly identified eligibles to educate the parent on the value of EPSDT, obtain a consent form, and make a clinic appointment. Much developmental assessment is done by the worker in the home. Screening centers are set up in a number of churches, meeting halls and other locations every two weeks; workers reduce "no-show" rates by sending a reminder card to parents, calling those who have telephones on the day of the appointment, and driving distances of over 50 miles to bring children to clinics. Transportation also is provided through an arrangement with local private taxi companies. A check list noting the client's next appointment is maintained by the

SOUTH CAROLINA  
DSS FORM 1724  
(CURRENT VERSION)



**SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES  
REQUEST FOR SERVICES**

⑩ EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

L

CLAIM CONTROL NUMBER (DO NOT WRITE IN THIS SPACE)

**PART I — IDENTIFICATION**

2. COUNTY NAME	3. CHILD'S NAME (First, Initial, Last)	4. COUNTY	5. CARRIER	6. RECIPIENT I.O.	7. BIRTHDATE	8. SEX	9. DATE PRINTED
10. FAMILY NO.	11. RECIPIENT NAME (PAYEE) (First, Initial, Last)	12. PERMANENT ADDRESS (Number, Street or Route, City, State & Zip Code)					
13. PATIENT'S SIGNATURE		14. DATE		15. WAS CONDITION RELATED TO			
				A. Patient's Employment <input type="checkbox"/> YES <input type="checkbox"/> NO			
				B. An Auto Accident <input type="checkbox"/> YES <input type="checkbox"/> NO			
17. IS PATIENT COVERED BY ANOTHER DENTAL PLAN?	18. DENTAL PLAN NAME	19. UNION LOCAL	20. GROUP NO.	21. NAME AND ADDRESS OF CARRIER			

**PART II — SCREENING**

22. PLACE OF SERVICE		23. VENDOR NUMBER		24. MO. / DA. / YR.	
25. CHECK APPROPRIATE BOX					
1. <input type="checkbox"/> HAS NO DEFECTS					
2. <input type="checkbox"/> HAS A DEFECT, NO DIAGNOSIS OR TREATMENT NECESSARY					
3. <input type="checkbox"/> HAS A DEFECT(S) REPAIRAL NECESSARY					
26. CHILD SHOULD BE REFERRED FOR DIAGNOSIS FOR THE FOLLOWING (No referral for known defects)					
27. DEFECT (1)	28. CODE	29. DEFECT (2)	30. CODE	31. DEFECT (3)	32. CODE
33. DEFECT (4)	34. CODE	35. DEFECT (5)	36. CODE	37. DEFECT (6)	38. CODE
39. DEFECT (7)	40. CODE	41. DEFECT (8)	42. CODE	43. DEFECT (9)	44. CODE
45. SIGNATURE OF OSS COUNTY DIRECTOR			46. SIGNATURE OF SCREENER		47. TITLE OF SCREENER

**PART III — DIAGNOSIS AND PLAN OF TREATMENT**

48. DATE		49. FTE/FL	50. DENTURE CODE	51. EMPLOY	52. TR	53. RUMPT	54. PRIOR AUTHORIZATION
MO. / DAY / YEAR							

IDENTIFY MISSING TEETH WITH "X"

TOOTH # OR LETTER	57. SERVICE	58. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	59. UNITS OF SERVICE	60. PLACE OF SERVICE	61. DATE SERVICE PERFORMED (MO. / DAY / YEAR)	62. PROCEDURE NUMBER	63. FEE	64. INDIVIDUAL PROVIDER NUMBER
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

65. PROVIDER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.		66. PROVIDER NUMBER	67. YOUR PATIENT'S ACCOUNT NO.	68. PROVIDER'S SIGNATURE
		69. APPROXIMATE COST OF TREATMENT		70.
		69. TOTAL LINES ENTERED	70. TOTAL UNITS	71. MEDICARE DEDUCTIBLE
				72. CO-INSURANCE
				GROSS TOTAL CHARGES 74.
				AMOUNT RECEIVED FROM OTHER SOURCES 75.
				AMOUNT RECEIVED FROM MEDICARE 76.
				NET AMOUNT BILLED FOR MEDICAL ASSISTANCE 77.

**PART IV — TREATMENT APPROVAL VALID CONCURRENT WITH ELIGIBILITY.**

<input type="checkbox"/> 78. TREATMENT DISAPPROVED (REASON)	79. DATE	<input type="checkbox"/> 80. TREATMENT APPROVED FOR USUAL, CUSTOMARY, & REASONABLE REIMBURSEMENT.
	MO. / DA. / YR.	
SIGNATURE OSS OFFICE OF HEALTH CARE FINANCING		

**PART IV — DATE TREATMENT COMPLETED**

31. MO. / DA. / YR.	32. Signature OSS County Director
---------------------	-----------------------------------

Provider Copy



SOUTH CAROLINA  
DSS FORM 1724  
(1976 VERSION)



**SOUTH CAROLINA  
DEPARTMENT OF SOCIAL SERVICES**

**REQUEST FOR SERVICES  
EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT**

**PART I - IDENTIFICATION**

1 COUNTY	2 CHILD'S NAME (first - middle - last)	3 RECIPIENT NAME (PAYER) (first - middle - last)	4 DATE
5 PERMANENT ADDRESS (Number, Street or Route, City, State & Zip Code)			6 PATIENT'S SIGNATURE
7 DATE			
8 WAS CONDITION RELATED TO A. Parent's Employment <input type="checkbox"/> YES <input type="checkbox"/> NO B. An Auto Accident <input type="checkbox"/> YES <input type="checkbox"/> NO		9 SOCIAL SECURITY NUMBER	10 MEDICAL IDENTIFICATION NUMBER
		COUNTY	CATEGORY
		AWARD NUMBER	BIRTH DATE (Mo Yr)
		SUFFIX	
11 IS PATIENT COVERED BY ANOTHER DENTAL PLAN?	12 DENTAL PLAN NAME	13 UNION LOCAL	14 GROUP NO.
15 NAME AND ADDRESS OF CARRIER			

**PART II - SCREENING**

16 PLACE OF SERVICE	CLINIC	VENDOR NUMBER	MO	DA	YR
CHECK APPROPRIATE BOX					
1 <input type="checkbox"/> HAS NO DEFECTS		2 <input type="checkbox"/> HAS A DEFECT, NO DIAGNOSIS OR TREATMENT NECESSARY		3 <input type="checkbox"/> HAS A DEFECT(S) REFERRAL NECESSARY	
DA <input type="checkbox"/>	PHY <input type="checkbox"/>	SC <input type="checkbox"/>	LP <input type="checkbox"/>	IMB <input type="checkbox"/>	PAR <input type="checkbox"/>
CHILD SHOULD BE REFERRED FOR DIAGNOSIS FOR THE FOLLOWING (No referral for known defects)					
					PROBLEM CODE
SIGNATURE OF DSS COUNTY DIRECTOR			SIGNATURE OF SCREENER		TITLE OF SCREENER

**PART III - DIAGNOSIS AND PLAN OF TREATMENT**

IDENTIFY MISSING TEETH WITH "X"		EXAMINATION AND TREATMENT RECORD—LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32. USE CHARTING SYSTEM SHOWN.				USUAL AND CUSTOMARY		
FACIAL		17 TOOTH NO. OR LETTER	18 SURFACES	19 DESCRIPTION OF SERVICE INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.	20 DATE SERVICE PERFORMED MO DAY YEAR	21 PROCEDURE NUMBER	22 FEE	TABLE OF ALLOWANCE
RIGHT								
LEFT								
FACIAL								
LINGUAL								
23 Diag. Code		24 Type						
25 Place		26 Provider's Name, Address, Phone Number SSAN Employer ID Number						
		Provider's Signature						
		APPROXIMATE COST OF TREATMENT						
		27 Amt. Paid						
		28 Bal. Due						
		29 Max. Allowable						
		30 Deductible						
		31 Carrier's						
		32 Carrier Pays						

**PART IV - A TREATMENT --- APPROVAL VALID CONCURRENT WITH ELIGIBILITY**

<input type="checkbox"/> TREATMENT DISAPPROVED (REASON)	DATE	<input type="checkbox"/> TREATMENT APPROVED FOR USUAL CUSTOMARY & REASONABLE REIMBURSEMENT
	MO DA YR	SIGNATURE DSS M.A. DIVISION

**PART IV - B - DATE TREATMENT COMPLETED**

MO	DA	YR	SIGNATURE DSS COUNTY DIRECTOR
----	----	----	-------------------------------

worker in each child's folder. The periodicity recall system is based on notebooks which are kept by each Health Check screener. These list all re-screens for the next two years.

The success of Idaho's program is largely attributable to a staff which, although small, is highly motivated and resourceful and feels it performs a vital service to its clients. They are sustained by a strongly supportive State management which organizes frequent meetings to encourage sharing of problems and solutions, conducts a public information campaign (television and radio spots, printed media), and assists in implementing needed policy changes. Workers feel their success is due to a respectful attitude toward the client, personal contacts, and an unwillingness to accept "no" as an answer.

### 3. MISSOURI

Reaching the adolescent EPSDT client is difficult in nearly all States. Missouri is attempting to improve this aspect of its program through a pilot project involving an innovative linkage with Department of Labor personnel and with assistance from the HCFA Regional Office in Kansas City. Through a new arrangement, Missouri Job Corps sites are being certified as EPSDT providers so that outreach, screening, and eventually, treatment services can be brought to Job Corps trainees, many of whom are EPSDT eligible. Because this practice was not yet quite operational at the time of this study, the site "visit" was conducted through telephone conversations with State and HCFA Regional Officials involved in the project. The linkage concept resulted from a position paper on the topic which delineated responsibilities of participating parties. The agreements on which the program will be based are shown as Exhibit C-III. Anticipated implementation problems include:

- Increased clerical work for enrollment of each Corps member in Medicaid and EPSDT
- Maintenance of separate medical records
- Complicated vouchering and accounting for services rendered
- Potential need for duplicate records due to difference in Job Corps and EPSDT medical service forms

Job Corps personnel are hopeful nonetheless that the project will both increase the quality and quantity of services available at the centers and reduce costs. This practice appears to have significant potential for States with Job Corps sites, and the results of the first year's effort will be of great interest to States seeking to improve service to the adolescent EPSDT group. Since a delay in securing Medicaid provider numbers for the Job Corps sites delayed the start of screening, however, the end date of the pilot has likely been extended.



AGREEMENT BETWEEN  
MISSOURI DIVISION OF FAMILY SERVICES  
AND  
EMPLOYMENT AND TRAINING ADMINISTRATION/JOB CORPS  
DEPARTMENT OF LABOR - REGION VII

Purpose of Agreement:

The purpose of this agreement is to develop a cooperative plan of health services for eligible persons who reside in the Department of Labor Job Corps facilities in the state of Missouri by using resources available through Region VII Job Corps facilities and Missouri Division of Family Services.

AGENCIES INVOLVED: Health Care Finance Administration/MEDICAID  
Dept. of Health, Education and Welfare  
Region VII

Employment and Training Administration/ Job Corps  
Department of Labor  
Region VII

Early Periodic Screening Diagnosis and Treatment  
Division of Family Services  
State of Missouri

CONTACTS:

Anne Broderick  
ETA/Job Corps  
911 Walnut, 10th floor  
Kansas City, Mo. 64106  
(816) 374-3661 FTS: 758-3661

Judy DiAmbrosio, Johnnie Terry Fleming  
Phil Chiarelli  
HCFA/Medicaid  
601 East 12th Street, 2nd floor  
Kansas City, Mo. 64106  
(816) 374-3763 FTS: 758-3763

Alan Welles, EPSDT Consultant  
Missouri Division of Family Services  
227 Metro Drive  
Jefferson City, Mo. 65101  
(314) 751-2447

### PROPOSAL

To initiate, on a pilot project basis, a joint effort between the Job Corps and Missouri EPSDT programs to cover medical expenses of eligible Corpsmembers by EPSDT.

There are two major requirements on the part of Job Corps: to register the centers and medical staff with the Missouri Title XIX Medicaid Provider System, and to encourage those Corpsmembers who may be eligible to enroll in the Missouri Medicaid program. The first requirement takes little effort; the second will require of Job Corps a great deal of energy and coordination with the Missouri Division of Family Services, our Missouri centers and our other recruiters. Once the initial coordination and planning are dealt with, we feel this pilot project will prove a model for a national effort.

### PROCEDURES

#### A. RESPONSIBILITIES OF MISSOURI DIVISION OF FAMILY SERVICES

1. The Division of Family Services (DFS) agrees to provide each Job Corps Center with a Title XIX provider number, including the physician's number.
2. DFS will verify the Medicaid eligibility status for the Job Corps population on a schedule to be arranged. The Centers will be responsible for providing to DFS the child's name, birthdate, Social Security number, parents' or guardian's name, home address, and the 12 digit Medicaid number (if known).
3. DFS agrees to pay the Center at the rate of \$25.00 per screening examination. Other services provided as a part of the examination, i.e. laboratory tests, immunizations, etc. can be billed to DFS separately and reimbursement will be provided accordingly. The Center may bill DFS on a monthly or bi-weekly basis.

4. DFS agrees to inform the Center on changes within the EPSDT program.
5. DFS will provide the Center with a copy of the completed screening form and the date when the child should be seen for another screening. In the case where the child was screened and identified as needing further diagnosis or treatment, and the State's records indicate the treatment has not been received, DFS will be responsible for following up with the Center to assist them in obtaining the necessary treatment.
6. DFS will provide the Center with a copy of the EPSDT screening provider manual and blank invoices. In addition, DFS will provide training on how to complete the required forms. This will be done in conjunction with the State's fiscal agent, Electronic Data Systems-Federal (EDSF).
7. DFS will provide the Centers with information about the EPSDT Program so the Centers can make parents and guardians aware of the services available.

B. RESPONSIBILITIES OF THE JOB CORPS

1. Job Corps must maintain proper verification in the youth's medical records to meet the requirements of 42CFR431.107. See Attachment 2.
2. Job Corps will be responsible for assuring that the services given under this agreement will be provided by a licensed physician or under the direct supervision of a licensed physician.
3. Job Corps will undertake to train screeners in the techniques necessary to screen for Medicaid information and eligibility.
4. Job Corps will disseminate EPSDT information.
5. Job Corps will accept on-site monitoring of the EPSDT activities by the Missouri Division of Health including but not limited to the quality of services delivered and clinic administration.



C. CONFIDENTIALITY

1. Job Corps and DFS shall maintain strict confidentiality of all records of individuals provided services under this agreement. With the exception of the provision of Paragraph 2 of this section, the contents of such records shall not be disclosed to anyone other than the Medicaid-eligible Corpsmember, or the parent/guardian of the Corpsmember if he/she is a minor or state ward, without written permission of the Corpsmember patient or the parent/guardian.
2. DFS shall have access to the Centers' Corpsmember health records for Medicaid eligible individuals served under this agreement at any reasonable time, provided that the information obtained by DFS is used only for the administration of the Medicaid program.

...Job Corps shall have access to DFS' records for any Corpsmember served under this agreement at any reasonable time provided that the information obtained by Job Corps is used only to carry out those Medicaid administrative activities that Job Corps has agreed to perform under this agreement. The "Administration of the Medicaid Program" and "Medicaid Administrative Activities" include, but are not limited to: determining eligibility, selecting methods of reimbursement, processing claims, conducting fair hearings, arranging interagency agreements, conducting outreach, and other similar activities.
3. All services provided by DFS and Job Corps under this agreement shall be approved in compliance with Title VI of the Federal Civil Rights Act of 1964 which stipulates that no person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied benefits of, or be subjected to discrimination under any program or activity receiving Federal Financial Assistance.
4. All programs and services provided by DFS and Job Corps under this agreement shall be provided in compliance with Section 504 of the Rehabilitation Act of 1973, which insures that the handicapped are not discriminated against, either as employees or as patients of any vendor participating in Job Corps or welfare programs.



Term of the Agreement:

June 1, 1980, through May 31, 1981

Provision:

This agreement may be renewed and/or revised for an additional year beginning June 1, 1981, and ending May 31, 1982, if both the Missouri Division of Family Services and the Employment and Training Administration/Job Corps feel the benefits justify continuation of the program. Any changes in procedures described in this agreement will be discussed and mutually accepted before implementation of changes.

We have reviewed this agreement between the Missouri Division of Family Services and the Employment and Training Administration/Job Corps and agree to operate according to the provisions outlined.

Employment and Training  
Administration/Job Corps

Missouri Division of Family Services

\_\_\_\_\_  
Regional Director, Job Corps

\_\_\_\_\_  
Director, Division of Family Services

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

#### 4. HCFA REGION X

Birch & Davis Associates, Inc. staff also met with the HCFA Region X EPSDT Coordinator, William J. Collins, who has pioneered a number of outreach efforts which have subsequently been adopted or adapted by other States. Chief among these are:

- "Dr. EPSDT"—a regional poster, coloring book, and other predominantly print media campaign which centered around a physician-kangaroo figure who promoted health check-ups. This program was specific to EPSDT and was discontinued in favor of the "Check It Out" program described below.
- "Check It Out"—differed from "Dr. EPSDT" in that it targeted the total community for preventive health messages. Much of the graphics and promotional work was donated, and messages were disseminated in the Washington test county through press releases, posters, buttons distributed by physicians, radio, and other public service air time, poster displays on public transit vehicles, coordination with Head Start programs and a "Child Health Day."

This program has been adapted by the State of California (in which it is known as "Check It Out with a Check-Up") which has expanded dissemination techniques (messages on grocery bags, performing dance troupes, displays at beaches and shopping malls, etc.) and prepared an implementation manual for use and adaptation by individual county EPSDT programs. A number of other States now are considering adaptation of "Check It Out" to their own program needs.

- Films and Public Service Television Spots—A group of four films were developed; the most popular of these has been "Hope Today," which effectively explains the EPSDT process and stresses the importance of early detection and treatment of illness. "Hope Today" was shown nationally in movie theaters as a short subject as well as to Parent-Teacher Association, YMCA, Girl and Boy Scout organizations, and in welfare and health department waiting rooms.

A number of television promotions also have been developed utilizing testimonials by sports and television celebrities. In all cases, time and materials were donated by both participating celebrities and television stations producing the spots. This mechanism also is being picked up and adopted in other areas of the country.

APPENDIX D

1981 NATIONAL EPSDT CONFERENCE  
WORKSHOP PARTICIPANTS





CASE MANAGEMENT AND INFORMATION  
SYSTEMS WORKSHOP

PARTICIPANT ROSTER

<u>Workshop Group</u>	<u>Participant Name</u>	<u>State or Organizational Affiliation</u>
<u>State Administered— Large EPSDT Population</u>	Arthur Mellin	New Jersey Division of Medical Assistance
	Elaine Pegalo	Connecticut Department of Income Maintenance
	Roberta E. Aber	Massachusetts Department of Public Welfare
	Nancy Yaun	Florida Department of Health and Rehabilitative Services
	Sandy Axelson	Florida Department of Health and Rehabilitative Services
	Elizabeth Silbernagel	Texas Department of Human Resources
	Claudia Langguth	Texas Department of Human Resources
	Jackie Drake	Texas Department of Human Resources
	Betty Zane Lindeman	Texas Department of Human Resources
	Carlotta Devereaux	Michigan Department of Social Services
	Linda Stella	Professional Health Research
	Vicki Horton	Automated Health Systems, Inc.
	Sara Rosenbaum	Childrens Defense Fund
	Lewis Crum	U. S. Department of Education Denver Regional Office

Linda Mazourek	HCFA/EPSTD Region II
Betty Collins	HCFA/EPSTD Region VI
Nelson Berry	HCFA/Bureau of Program Operations, Central Office
Mary Abdalla	HCFA/Office of Child Health, Central Office
Karyn C. Sheridan	HCFA/Office of Legislation and Policy, Central Office

State Administered—  
Small EPSTD Population

Cheryl J. Owen	Colorado Department of Social Services
Myrle Myers	Colorado Department of Social Services
Phyllis Payne	Colorado Department of Social Services
Ann Gilmore	Colorado Department of Health/Maternal and Child/Health
Margie Dennison	Utah Department of Health
Kathi Kellen	Iowa Department of Social Services
Troy E. Posey	West Virginia Department of Welfare
Mary Vollin	Medicaid/Medicare Management Institute, HCFA Central Office

State Supervised/  
County Administered—  
Large EPSTD Population

Susan Hunt	North Carolina Department of Medical Assistance/Health Resources.
Sheila Swaiman	Minnesota Department of Health
Karen Collinson	Minnesota Department of Public Welfare

## APPENDIX D(3)

Karen Hogan	New York State Department of Social Services
Rita Hines	Virginia Department of Welfare
Victoria Simmons	Virginia Department of Health
Wanda Symmes	Georgia Department of Human Resources/Physical Health
Lula McGarity	Georgia Department of Human Resources/Family and Childrens Services
Bessie Prince	Georgia Department of Human Resources/Family and Childrens Services
Siegried Centerwall, M.D.	California Department of Health Services
Colleen McMurray	Ohio Department of Public Welfare
Susan Fox	Professional Health Research
Dick Anderson	Computer Science Corporation
Cathy Rhodes	HCFA/EPSTD Region IV
Mary L. Canale	HCFA/EPSTD Region IX
J. L. Sprol	Medicare/Medicaid Management Institute HCFA Central Office
Bob Nakamoto	HCFA, Central Office
<u>State Supervised/ County Administered— Small EPSTD Population</u>	Steve Vajna
Maureen Maier	Wyoming Department of Health and Social Services
Kerry Mondy	Colorado Tri-County Health/EPSTD

Jan Reimer	Colorado Department of Health
Ben Trexel	Colorado Department of Social Services
Bonita Charvat	EPSDT, Denver, Colorado
Patricia Gravelby	EPSDT, Denver, Colorado
Carlos Fierro	New Mexico Department of Health Services
Sandi Kahlandt	Nebraska Department of Public Welfare
Jim Jollie	South Carolina Department of Social Services
Betty Sisk	South Carolina Department of Social Services
Anne Lemos	South Carolina Department of Social Services
Michael Gelder	Michael Gelder and Associates
Lauren P. Smith	HCFA, Region VIII
J. S. Stockley	DHHS/ICA
Pat Hotkowski	HCFA, Office of Child Health



PROGRAM DESIGN WORKSHOPPARTICIPANT ROSTER

<u>Workshop Group</u>	<u>Participant Name</u>	<u>State or Organizational Affiliation</u>
<u>State Supervised/ County Administered— Large EPSDT Population</u>	Karen Collinson	Minnesota Department of Public Welfare
	Sheila Swaiman	Minnesota Department of Health
	Susan Hunt	North Carolina Department of Medical Assistance/Health Resources
	Karen Hogan	New York State Department of Social Services
	Rita Hines	Virginia Department of Welfare
	Victoria Simmons	Virginia Department of Health
	Wanda Symmes	Georgia Department of Human Resources/Physical Health
	Lula McGarity	Georgia Department of Human Resources/Family and Childrens Services
	Bessie Prince	Georgia Department of Human Resources/Family and Childrens Services
	Edurnlyn Heyward	Georgia Department of Medical Assistance
	Siegried Centerwall, M.D.	California Department of Health Services
	Colleen McMurray	Ohio Department of Public Welfare

Susan Fox	Professional Health Research
Dick Anderson	Computer Science Corporation
Cathy Rhodes	HCFA/EPSTD Region IV
Mary L. Canale	HCFA/EPSTD Region IX
J. L. Sprol	Medicare/Medicaid Management Institute HCFA Central Office
Bob Nakamoto	HCFA, Central Office
Pat Hotkowski	HCFA, Office of Child Health
<u>State Supervised/ County Administered— Small EPSTD Population</u>	
Steve Vajna	Wyoming Department of Health and Social Services
Carlos Fierro	New Mexico Department of Health Services
Sandi Kahlandt	Nebraska Department of Public Welfare
Jim Jollie	South Carolina Department of Social Services
Betty Sisk	South Carolina Department of Social Services
Anne Lemos	South Carolina Department of Social Services
J. S. Stockley	DHHS/ICA
Virginia Walker	Mississippi Medicaid Commission
Joyce Jackson	HCFA, Medicare/Medicaid Management Institute

State Administered--  
Small EPSDT Population

Joy Mornell	Vermont Department of Health
Loretta Fujiwara	Hawaii Department of Social Services
Lenore Ishimi	Hawaii Department of Health
Richard Currier	Michigan Department of Public Health
Margie Dennison	Utah Department of Health
Troy E. Posey	West Virginia Department of Welfare
Cheryl J. Owen	Colorado Department of Social Services
Myrle Myers	Colorado Department of Social Services
Phyllis Payne	Colorado Department of Social Services
Jan Reimer	Colorado Department of Health
Flora Mae Danforth	EPSDT, Denver, Colorado
Bonita Charvat	EPSDT, Denver, Colorado
Sara Rosenbaum	Childrens Defense Fund
Mary Vollin	Medicaid/Medicare Management Institute, HCFA Central Office
Bill Hiscock	HCFA, Office of Child Health
Mary Tierney	HCFA, Office of Child Health

State Administered--  
Large EPSDT Population

Arthur Mellin	New Jersey Division of Medical Assistance
Elaine Pegalo	Connecticut Department of Income Maintenance
Roberta E. Aber	Massachusetts Department of Public Welfare

APPENDIX D(8)

Nancy Yaun	Florida Department of Health and Rehabilitative Services
Sandy Axelson	Florida Department of Health and Rehabilitative Services
Jackie Drake	Texas Department of Human Resources
Betty Zane Lindeman	Texas Department of Human Resources
Lois Bronic	D. C. Department of Human Services
Ruth Steckert	New Jersey, EPSDT
Carlotta Devereaux	Michigan Department of Social Services
Linda Stella	Professional Health Research
Vicki Horton	Automated Health Systems, Inc.
Michael Gelder	Michael Gelder and Associates
Linda Mazourek	HCFA/EPSTD Region II
Nelson Berry	HCFA/Bureau of Program Operations, Central Office
Mary Abdalla	HCFA/Office of Child Health, Central Office
Jonathan Nachsin	HCFA, Region V
Vernon Smith	Michigan Medical Services Administration
James McKittrick	Pennsylvania Department of Public Welfare
Bill Schmeling	HCFA, Region VII



OUTREACH/INFORMING WORKSHOPPARTICIPANT ROSTER

<u>Workshop Group</u>	<u>Participant Name</u>	<u>State or Organizational Affiliation</u>
<u>Welfare Agencies</u>	James McKittrick	Pennsylvania Department of Public Welfare
	Loretta Fujiwara	Hawaii Department of Social Services
	Elaine Pegalo	Connecticut Department of Income Maintenance
	Roberta E. Aber	Massachusetts Department of Public Welfare
	Jackie Drake	Texas Department of Human Resources
	Betty Zane Lindeman	Texas Department of Human Resources
	Carlotta Devereaux	Michigan Department of Social Services
	Linda Stella	Professional Health Research
	Cheryl J. Owen	Colorado Department of Social Services
	Myrle Myers	Colorado Department of Social Services
	Phyllis Payne	Colorado Department of Social Services
	Troy E. Posey	West Virginia Department of Welfare
	Sheila Swaiman	Minnesota Department of Health
	Karen Collinson	Minnesota Department of Public Welfare
	Karen Hogan	New York State Department of Social Services

Colleen McMurray	Ohio Department of Public Welfare
Sandi Kahlandt	Nebraska Department of Public Welfare
Jim Jollie	South Carolina Department of Social Services
Betty Sisk	South Carolina Department of Social Services
Anne Lemos	South Carolina Department of Social Services
Bonita Charvai	EPSDT, Denver, Colorado
Flora Mae Danforth	EPSDT, Denver, Colorado
Martina Brown	Georgia Department of Medical Assistance
Lauren P. Smith	HCFA, Region VIII
Pat Hotkowski	HCFA, Office of Child Health
<u>Umbrella Agencies</u>	
Carlos Fierro	New Mexico Department of Health Services
Steve Vajna	Wyoming Department of Health and Social Services
Nancy Yaun	Florida Department of Health and Rehabilitative Services
Sandy Axelson	Florida Department of Health and Rehabilitative Services
Susan Hunt	North Carolina Department of Medical Assistance/Health Resources
Val Lennon	Alaska Department of Health and Welfare
Bill Collins	HCFA/EPSDT Region X
<u>Health and Other Agencies</u>	
Rita Hines	Virginia Department of Welfare

## APPENDIX D(11)

Ruth Stekert, M.D.	New Jersey Division of Medical Assistance
Wanda Symmes	Georgia Department of Human Resources/Physical Health
Lula McGarity	Georgia Department of Human Resources/Family and Childrens Services
Bessie Prince	Georgia Department of Human Resources/Family and Childrens Services
Margie Dennison	Utah Department of Health
Arthur Mellin	New Jersey Division of Medical Assistance
Siegried Centerwall, M.D.	California Department of Health Services
J. L. Sprol	Medicare/Medicaid Management Institute, HCFA Central Office
Bob Nakamoto	HCFA, Central Office
Linda Mazourek	HCFA/EPSDT Region II
Dick Anderson	Computer Science Corporation
Cathy Rhodes	HCFA/EPSDT Region IV
Dan O'Connor	HCFA, Central Office
Joy Morrell	Vermont Department of Health
Virginia Walker	Mississippi Medicaid Commission
Jan Reimer	Colorado Department of Health
Claire Mueller	Orange County (California) Human Service Agency

Liz DeLoach

Medicaid/Medicare  
Management Institute, HCFA

Bill Hiscock

HCFA Office of Child Health



SCREENING, DIAGNOSIS, AND  
TREATMENT WORKSHOP

PARTICIPANT ROSTER

<u>Workshop Group</u>	<u>Participant Name</u>	<u>State or Organizational Affiliation</u>
<u>Group A</u>	Elizabeth Silbernagel	Texas Department of Human Resources
	Claudia Langguth	Texas Department of Human Resources
	Roberta E. Aber	Massachusetts Department of Public Welfare
	Carlotta Devereaux	Michigan Department of Social Services
	Karen Hogan	New York State Department of Social Services
	Siegried Centerwall, M.D.	California Department of Health Services
	Colleen McMurray	Ohio Department of Public Welfare
	Dick Anderson	Computer Science Corporation
	Linda Stella	Professional Health Research
	Vicki Horton	Automated Health Systems, Inc.
	Michael Gelder	Michael Gelder and Associates
	Karyn C. Sheridan	HCFA/Office of Legislation and Policy, Central Office
	Betty Collins	HCFA/EPSTD Region VI
	Mary L. Canale	HCFA/EPSTD Region IX
	James McKittrick	Pennsylvania Department of Public Welfare

<u>Group B</u>	Vernon Smith	Michigan Medical Services Administration
	Fred Hanks	Automated Health Systems
	Bob Doran	Automated Health Systems
	Jim Jollie	South Carolina Department of Social Services
	Betty Sisk	South Carolina Department of Social Services
	Anne Lemos	South Carolina Department of Social Services
	Susan Hunt	North Carolina Department of Medical Assistance/Health Resources
	Rita Hines	Virginia Department of Welfare
	Victoria Simmons	Virginia Department of Health
	Wanda Symmes	Georgia Department of Human Resources/Physical Health
<u>Group C</u>	Nancy Yaun	Florida Department of Health and Rehabilitative Services
	Sandy Axelson	Florida Department of Health and Rehabilitative Services
	Cathy Rhodes	HCFA/EPSTD Region IV
	Jonathan Nachsin	HCFA/EPSTD Region V
	Elaine Pegalo	Connecticut Department of Income Maintenance
	Steve Vajna	Wyoming Department of Health and Social Services
	Carlos Fierro	New Mexico Department of Health Services

Sandi Kahlandt	Nebraska Department of Public Welfare
Sheila Swaiman	Minnesota Department of Health
Karen Collinson	Minnesota Department of Public Welfare
Margie Dennison	Utah Department of Health
Kathi Kellen	Iowa Department of Social Services
Troy E. Posey	West Virginia Department of Welfare
Mary Vollin	Medicaid/Medicare Management Institute, HCFA Central Office
Cheryl J. Owen	Colorado Department of Social Services
Myrle Myers	Colorado Department of Social Services
Phyllis Payne	Colorado Department of Social Services
Ann Gilmore	Colorado Department of Health/Maternal and Child Health
Lula McGarity	Georgia Department of Human Resources/Family and Childrens Services
Bessie Prince	Georgia Department of Human Resources/Family and Childrens Services
Lauren P. Smith	HCFA, Region VIII
J. S. Stockley	DHHS/ICA
Pat Hotkowski	HCFA, Office of Child Health
Linda Mazourek	HCFA/EPSTD Region II

Nelson Berry

HCFA/Bureau of Program  
Operations, Central Office

Mary Abdalla

HCFA/Office of Child Health,  
Central Office

Sara Rosenbaum

Childrens Defense Fund



APPENDIX E

SELECTED BIBLIOGRAPHY UPDATE



National Child Day Care Association. A Manual for the Training of Paraprofessionals in E.P.S.D.T. and Child Development Programs, Washington, D.C., 1978.

This manual is intended to be a comprehensive document that will facilitate training paraprofessionals. Originally, the focus was on paraprofessionals who would be working in EPSDT programs. The document, however, is a valuable tool for persons in all programs that serve children. It covers, in some detail, four areas considered extremely relevant: human relations, medical concepts, emotional development and child development. It not only gives content in these areas, but also provides the trainer with practical suggestions for the "how to train" and lists a variety of additional resources. Besides providing new information for the paraprofessional, this manual is at least a comprehensive review for the professional.

Department of Health and Human Services and Department of Education. EPSDT - A Guide for Educational Programs, Washington, D.C., 1980.

The school setting can be an important means of improved identification of health problems, of increasing students' access to both curative and preventive health services, and of more appropriate use of health care resources through improved student understanding of their health problems. The schools may be important catalysts in developing linkages of school services through the family to public, private, and other community health and social services. This guide was developed specifically to encourage and assist State education agencies (SEAs), local education agencies (LEAs), State and local health agencies, and others in becoming actively involved in their State's EPSDT program by using the school setting as one resource in a total system of health care wherever appropriate. Its timely development is a result of the need for States to develop a more effective relationship between public and private EPSDT providers and public schools. The establishment of such a relationship - health and education - increases advantages the eligible children could have in receiving comprehensive health care and services. The Guide is intended to reflect the necessary content and activities to be taken to achieve maximum coordination between health and education.

University of Texas Health Science Center at San Antonio, Regional Health Services Research Institute. Phase II Report, Early and Periodic Screening, Diagnosis and Treatment Impact, Introduction: Phase I Summary and Problems, San Antonio, TX, 1973.

The Phase I EPSDT report of October 15, 1972, indicated that no one was acting on the premise of saving medical costs and reducing hospitalization, while maintaining quality health and preventing problems. Therefore, Phase II was initiated to study more communities in the same States and choose additional States which had both an exemplary aspect of providing EPSDT and had screened enough children to allow decent sample sizes. The data collection study in the phase was never meant to provide definitive data, but only to see what information is available and to attempt to track children through a system. A conference was convened to determine the type of managerial and evaluative questions that administrators at various levels have about the program. At that conference, the existing reporting requirements and stated program objectives were deemed acceptable for the beginning of the effort, but not significant for the successful continuation beyond two years into the program. The recommendations resulting from the conference, along with recommended reporting requirements, are presented in this report.



University of Texas Health Science Center at San Antonio, Regional Health Services Research Institute. Phase II Report, Early and Periodic Screening, Diagnosis and Treatment Impact - Program Characteristics, San Antonio, TX, 1973.

During the Phase II study, 23 localities in eight States were visited and various levels of data were gathered at each locality. The States included in the study were chosen for the most part as States representing possible models of tracking systems and techniques in implementing screening in varying geographical and provider system environments. The successful implementation of the EPSDT program in a particular State seemed to depend upon the enthusiasm and interest of the Medicaid Director, the assignment of responsibility to a single person for the conduct of the program in the State, the provision of sufficient personnel at the State level to carry out all phases of the complex effort, the effective linkage with community organizations, and the detailed involvement of the medical profession. This report charts the program characteristics of the eight States selected.

Northwestern University, Center for Health Services and Policy Research. Executive Summary - An Assessment of the Validity of the Results of HCFA's Demonstration and Evaluation Program for the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT): A Metaevaluation, Evanston, IL, 1979.

This document reviews the validity of the information contained in the 21 reports of the 15 demonstration/evaluation projects relevant to the EPSDT program which were funded by HCFA (formerly SRS) from 1972 to 1978. The review was conducted by a multidisciplinary team from the Center for Health Services and Policy Research of Northwestern University. The review process entailed the elaboration of formal decision rules to assess the validity of the parameter estimations and causal inferences in the reports. In the process, stress was placed on the integration of findings across the reports. As such, the review qualifies as an evaluation of evaluations (metaevaluation) of the type: critical review of multiple completed studies with no raw data manipulation.

University of Texas Health Science Center at San Antonio, Regional Health Services Research Institute. Phase II Report, Early and Periodic Screening, Diagnosis and Treatment Impact - Reporting Requirements, San Antonio, TX, 1973.

Phase II was initiated to study more communities in selected States with the intent of ascertaining what information is available and to attempt to track children through a system. Twenty-three localities in eight States were visited and various levels of data were gathered at each locality. This document contains the recommended reporting requirements and data needs for the Federal, State and local levels. An evaluation manual will follow with recommendations on how to implement the requirements and the usefulness of each.



Welfare Research, Inc. Utilizing Existing Health Data Systems to Demonstrate A Model for EPSDT Planning and Evaluation, Albany, NY, 1977.

This project was undertaken to demonstrate the viability of a Federal evaluation strategy predicated on the improvement of data systems presently in operation at State and local levels. The result of independent authority in EPSDT has been widespread variation in program implementation. Of particular importance is the degree to which State and local projects have developed different support systems to meet their needs, especially systems which provide data describing program operations. In many cases local information user needs are different from Federal information needs. The proposal submitted by Roosevelt Hospital called for a demonstration in which existing health data systems would be utilized to meet State and local reporting requirements, in particular those needed for evaluation and planning. This report details the project's findings.

University of Texas Health Science Center at San Antonio, Regional Health Services Research Institute. Phase II Report, Early and Periodic Screening Diagnosis and Treatment Impact - Special Studies and Sections, San Antonio, TX, 1973.

Phase II was initiated to study more communities in selected States with the intent of ascertaining what information is available and to attempt to track children through a system. This report details findings in the following areas: 1) cost effectiveness of hearing testing with impedance bridge, 2) lead screening in Louisiana, 3) progress on the Barrio Comprehensive Child Health Care Center in San Antonio, Texas, 4) New Jersey's physicians' survey, 5) study of non-utilizers in New Jersey, 6) pilot study to rank abnormalities for screening, and 7) an annotated bibliography on outreach and followup.

American Academy of Pediatrics. Increased Professional Provider Participation in State and Local EPSDT Programs, Evanston, IL, 1976.

This study was initiated to determine ways and means of enlisting increased interest, support and effective participation of professional health care providers in the implementation of EPSDT. The effort pinpoints a number of problem areas in the delivery of service. Some of the findings are inadequate fees, slow payment and paperwork; missed appointments; private physicians not allowed to screen; and no follow-through, inadequate records, over-diagnosis, and inappropriate screening. Among important developments flowing from this study were establishment of a viable American Academy of Pediatrics EPSDT organization in each State, and increased communication between practitioners and State and Federal staff.

University of Texas Health Science Center at San Antonio, Regional Health Services Research Institute. Phase II Report, Early and Periodic Screening, Diagnosis and Treatment Impact - Analysis of Data Collected During Phase II, San Antonio, TX, 1973.

During the Phase II study, 23 localities in eight States were visited and various levels of data were gathered at each locality. The States included in the study were chosen for the most part as States representing possible models of tracking systems and techniques in implementing screening in varying geographical and provider system environments. This report provides an analysis of all data collected during Phase II.

George Washington University, Social Research Group. Toward Interagency Coordination: FY '75 Federal Research and Development Activities Pertaining to Early Childhood - Fifth Annual Report, Washington, D.C., 1975.

In 1970, the Interagency Panel on Early Childhood Research and Development was convened by the Director of the Office of Child Development at the request of the Secretary of the Department of Health, Education, and Welfare and the Director of the Office of Management and Budget. The primary mission of the Panel is to facilitate Federal interagency coordination and cooperation in the planning, funding and analysis of early childhood research and development (covering the age range of prenatal through nine years). This report presents information on Federally-funded early childhood research projects active in FY '75. Some of these projects are continuing projects and were included in the data base of the last annual report; others are new starts. Thus, this report describes and analyzes ongoing research only, and does not address completed projects. Information about research activities supported and planned during the fiscal years 1971 through 1974 can be obtained from the Panel's previous annual reports (Grotberg, Searcy & Sowder, 1972; Hertz & Harrell, 1974; Hertz, Harrell, & Grotberg, 1973; Stearns, Searcy, & Rosenfeld, 1971).

University of Texas Health Science Center at San Antonio, Regional Health Services Research Institute. Phase II Report, Early and Periodic Screening, Diagnosis and Treatment Impact - State Narrative Descriptions - Iowa, San Antonio, TX, 1973.

The information presented in this report relates to Iowa's conduct of the EPSDT program. The outreach is accomplished by informing the recipient at the initial contact for eligibility and at each subsequent six-month redetermination. The statement of availability of service is included in a brochure published by the Department of Social Services. Iowa has decided to use both private physicians and screening centers to perform EPSDT. The screening centers are primarily expanded well child conferences and public health nurse oriented screens in the larger counties. The State has done a fine job of organizing the outreach, screening and followup process and communicating it in writing to the screening centers, county departments of social services, and screening physicians through the use of supplements to the employee manuals, provider manuals, and letters to the screening centers. Selected pages from the supplements are included in this report as an appendix because they are exemplary in illustrating the importance of detailed written communication to all concerned.



University of Texas Health Science Center at San Antonio, Regional Health Services Research Institute. Phase II Report, Early and Periodic Screening, Diagnosis and Treatment Impact - Methodology, San Antonio, TX, 1973.

This report details steps in the methodology of Phase II whose mission was to study more communities in States with the intent of ascertaining what information is available and to attempt to track children through a system. Since it was discovered in Phase I that very little was happening in EPSDT in terms of tracking systems for determining the extent to which any given child with a particular finding of a problem in screening got care, that very little data was being collected where screening did occur, and that many State programs were still in the development stage, it was decided the emphasis would switch from one of cost-benefit analysis to one of trying to isolate viable programmatic elements in "successful," but varied EPSDT programs. Since it was not really correct to do a full cost-benefit analysis of a program until it is in its finest functioning form, emphasis was placed on ways to improve existing programs. A 2-pronged approach was planned. One was a mini-conference of technical consultants invited to San Antonio to discuss the decision-making questions that would need to be answered and the data that would be needed to answer those questions as they would appear 2-3 years hence. After the conference, then, data collection would begin according to the suggestions at the conference. Each participant was sent a copy of the summary of the Phase I report and a request to suggest the type of questions that needed to be asked in the management and evaluation of the EPSDT program.

Macro Systems, Inc. Evaluation of the New York State Child Health Assurance Program, Volume I of II, New York, NY, 1976.

This study was initiated to form the basis of an action plan through which the local, State and Federal officials involved with CHAP, the State's version of EPSDT, could strengthen the delivery of health care services to needy children. One of the specified objectives of the study is to isolate and describe variables that appear to be critical to successful implementation and operation of each programmatic element of CHAP. Four counties were selected for indepth study, each reflecting early indications for success. This report covers a wide range of topics -- from the most detailed descriptions of administrative procedures to issues that may have national significance. Its recommendations are designed to strengthen both the program and the relationships among the parties responsible for implementation.

Macro Systems, Inc. Evaluation of the New York State Child Health Assurance Program, Volume II of II, New York, NY, 1976.

This is the second of a two-volume report of the evaluation of New York's Child Health Assurance Program. The study was initiated to form the basis of an action plan through which the local, State and Federal officials involved with CHAP could strengthen the delivery of health care services to needy children. The report details the contractor's efforts in the four counties selected for intense study, as well as bibliographical information and tabulation of the Statewide questionnaire. One county was chosen from each of four categories: Counties suburban to New York City (Nassau County); Upstate

urban counties with a major metropolitan area (Onondaga County); Upstate urban counties without a major metropolitan area (Chemung County); and Rural counties (Herkimer County). The four counties were studied in detail as to their planning, organization and staffing, and operation.

Texas Department of Human Resources, Office of Medical Programs, Research and Demonstration Division. Final Report-EPSDT Dallas Project, Dallas, TX, 1978.

The Dallas project, EPSDT in an Urban Setting, was designed to address problems of low recipient participation and high costs of EPSDT services. Innovative variations in outreach and followup services together with a unique mix of service delivery staff are conducted over a three-year period: July, 1975 through June, 1978. All activities are administered by the Department of Human Resources (TDHR), the State delegated Title XIX agency. Project data statistically are evaluated by the Health Services Research Institute (HSRI) of the University of Texas Health Sciences Center at San Antonio, Texas under contract to TDHR. The target area is comprised of seven zip codes are utilized for experimental variables; two are for control purposes. Overall results of project activities produced pertinent findings regarding EPSDT. These findings are based on a completion of data gathered from all sectors during the project's three years as opposed to specific demonstration variables.

Community Health Foundation. New Jersey Program Description, Evanston, IL, 1979.

Community Health Foundation (CHF) conducts its needs assessment of the New Jersey EPSDT program during November, 1978. Prior to this assessment, CHF mailed a Needs Assessment Questionnaire to the New Jersey Division of Medical Assistance and Health Services (DMAHS). The program description contains references to the "adequate/equivalent care" system and "main-stream." The New Jersey EPSDT program is based on the premise that children under regular medical supervision do not need separate periodic screening. Therefore, EPSDT services are promoted only for children receiving inadequate health care services through Medicaid.

International Planning Associates, Inc. Early and Periodic Screening, Diagnosis and Treatment Demonstration Project - Interim Evaluation Report Through June 30, 1978, Volume II, Miami, FL, 1978.

The Dade County, Florida, EPSDT Demonstration Project was approved and funded in 1976 under Section 15 of Title XI and Title XIX of the Social Security Act. The goal of the project is to develop and evaluate innovative techniques to bring Medicaid eligibles into the health care system, providing specific and reliable documentation and data on the effectiveness and cost of these techniques so as to bring about the establishment of health care and maintenance programs that are medically, socially, and financially effective. In order to accomplish this goal, several major objectives have been conceived: to coordinate EPSDT and other related programs for the most effective



and efficient utilization of community resources; to increase accessibility to the health care system by employing personal case management techniques, including evaluation of the effects of ethnicity on the success of case intervention; to identify children with health problems through collaboration with the public school system; to assess various techniques for detecting developmental disabilities; to increase the relevance of Medicaid services for the older child; and to develop support for the EPSDT concept in the community through contact with the health care and social service leadership. This report summarizes first year activities, explains modifications that took place in the project design and evaluate the effectiveness of the project.

Community Health Foundation. EPSDT Interim System Evaluation - Design Document - State of Louisiana, Evanston, IL, 1977.

This study is the result of a comprehensive evaluation of the state-of-the-art operational facilities in the State of Louisiana regarding EPSDT tracking capabilities. This evaluation is part of an overall technical assistance plan, implemented in the State for the contract year 1976-77. The purpose of this study is to determine the feasibility of implementing an automated interim EPSDT reporting, monitoring and tracking system that will both satisfy Federal EPSDT reporting requirements and enable State personnel to better control, report and coordinate their EPSDT activity. After analysis of the information accumulated during the study period, the contractor recommends that the State consider implementing an automated "interim" system to meet short term requirements. The system is designated interim only from the standpoint that the Federally sponsored MMIS/EPSDT system modules will eventually be made available and may prove to provide long range, comprehensive EPSDT solution.

Community Health Foundation. State of Colorado End-of-Year Report, Evanston, IL, 1977.

During 1976-77, the role of Community Health Foundation (CHF) in Colorado was to act as both a consultant and change agent in the complete redesign of the Colorado EPSDT program. This is a report of the effort required: 1) building the commitment for change among the various personnel having a role in EPSDT; 2) working on planning for change; 3) seeing that relevant issues were considered; 4) providing technical and/or organizational inputs for developing a new EPSDT program; 5) assuring intercommunications among the divisions of the Department of Social Services (DSS) and between DSS and other agencies; and 6) offering the continuous stimulation, encouragement and direction needed to proceed with redevelopment and funding of the EPSDT program. The result is a new EPSDT program design to provide outreach and case management to eligible families, which entails the sharing of responsibilities between DSS and the Department of Health. Thus, in meeting the requirements of outreach and case management, the State would be brought into compliance with Federal regulations.

Health Services Research Institute, University of Texas Health Science Center at San Antonio. Training Program for Case Finders and Case Monitors in EPSDT, San Antonio, TX, (undated).

This training program was prepared as a common base of instruction to present to all personnel involved in new EPSDT demonstration projects whose focus is the investigation of case finding and case monitoring. A modular

structure of the information is employed, since people of varying experience, education, and responsibilities will be exposed to the training. Persons can attend the sessions that cover material they are not familiar with and avoid sessions that would be redundant for them.

Health Services Research Institute, University of Texas Health Science Center at San Antonio. Workbook for EPSDT Case Finders and Case Monitors, San Antonio, TX.

This workbook was prepared to serve in conjunction with the Training Program for Case Finders and Case Monitors in EPSDT. It serves two functions: first, it is to be used as a programmed learning text, and second, it may serve as a manual for later reference. The feedback exercises included in the workbook are to help the trainee assess the level of knowledge gained from preceding sections and to indicate when review is necessary.

Community Health Foundation. Colorado Program Manual, Evanston, IL. (undated).

This manual is in fulfillment of a contractual effort by the Community Health Foundation to assist Colorado in implementing a successful EPSDT program. Its policies and procedures serve several critical functions in guiding the implementation process. The manual is organized into components corresponding with the fundamental EPSDT program management activities, that is, identification of eligibles, notification, scheduling, outreach, case management, identification of health care resources and the documentation process. It also contains the Federal regulations used to determine whether or not a State is in compliance with the regulations.

Community Health Foundation. State of Georgia Preliminary Report, Evanston, IL, 1976.

This is a preliminary report based on the needs assessment findings of the Community Health Foundation (CHF). (The report is subject to revision based on input from the State of Georgia.) The State medical assistance program identified four major problem areas which prompted their interest in the CHF technical assistance contract. The four areas were: provider relations, transportation, broken appointments and outreach. The needs assessment confirmed that each of these areas was deterring program effectiveness and the delivery of needed services to eligible children. Additionally, interviews indicated another significant problem: the lack of integration and coordination of EPSDT with other publicly sponsored programs. This report provides a summary of the problems and recommendations for their solutions.

Community Health Foundation. Final Report - EPSDT Technical Assistance Program, July 1, 1975 - June 30, 1976, Evanston, IL, (undated).

Community Health Foundation (CHF) was awarded a contract to provide technical assistance to nine States. The selected States were California, Colorado, Hawaii, Louisiana, Maryland, Minnesota, North Dakota, Pennsylvania and Washington. The assistance was to be tailored to the individual needs and potential resources of the States. The State and the contractor together were required to conduct an orderly and comprehensive evaluation of program activities, determine problem areas, specify needs to overcome these problems and



undertake activities at the State and local levels to meet the identified needs. The contractor was to develop methods of performing needs assessments, develop a central core staff, develop lists of consultants and compile lists of resource materials that might assist individual programs. In all cases, the States were to set priorities for needs and assistance activities. Ultimately, the States were to gain experience in and develop a capability for providing assistance to their own local programs so that outside assistance could be phased out. This report reviews the needs assessment for each selected State and recommendations for solution of the problems identified. Findings reveal that support for EPSDT at all levels is regrettably low.

Philadelphia Health Management Corporation. Policy Implication Paper for the First Interim Report of A Study of the Process, Effectiveness and Costs of the EPSDT Program in Southeastern Pennsylvania, Philadelphia, PA, 1979.

This study conducted during the period of October 1, 1978 through September 30, 1980, addresses the issues of preventive services through the analysis of existing data from child health screening services (EPSDT) in southeastern Pennsylvania. This first Interim Report primarily consists of a descriptive analysis of the southeastern Pennsylvania EPSDT program. Eligible individuals, clients, and provider sites have alternately been used as the unit of analysis, and comparisons have been made within the program and to external (national) baselines. There follows, in question-answer format, some of the more important policy implications of the findings.

Philadelphia Health Management Corporation. A Study of the Process, Effectiveness, and Costs of the EPSDT Program in Southeastern Pennsylvania - Second Interim Report - Conceptual Modeling, Philadelphia, PA, 1979.

This is the second interim report of a two-year project to study data collected by the EPSDT program in southeastern Pennsylvania. The specific objectives of the study are: 1) description of the eligible population, the providers of care, and the screening process and results; 2) identification of interactions between eligible, provider, screening, and geographic variables; 3) development of a provider typology or classification system; 4) determination of the impact of intervention methods used in each phase of EPSDT, such as case finding, risk identification and risk reduction; 5) assessment of the variables affecting provider type effectiveness; and 6) determination of a baseline cost of EPSDT, and how it is affected by client and provider characteristics and the prevalence of different conditions. This report presents a conceptual model of that program. Three sequential phases of program

American Management Systems, Inc. An Evaluative Study of Early and Periodic Screening, Diagnosis, and Treatment Program in Ohio and Wisconsin, Oak Brook, IL, 1974.

The purpose of this project is to study the implementation of the EPSDT program in Ohio and Wisconsin and to make recommendations to DHEW's Region V on how it might assist the States in improving and fully developing the EPSDT program. Ohio and Wisconsin were chosen because of their dissimilar approach to implementation of the EPSDT program -- a key difference being Ohio's use of private physicians to provide screening services versus Wisconsin's use of public health nurses. The objectives are 1) to develop a thorough managerial

analysis of EPSDT implementation in Ohio and Wisconsin; 2) to describe the types of interagency agreements and cooperative arrangements that the States developed to support EPSDT implementation; 3) to assess the strengths and weaknesses of State administrative arrangements and selected program elements; and 6) to evaluate the role of the regional office in supporting the States and to make recommendations as to how the States and the regional office can facilitate rapid development of the EPSDT program. The report is organized to reflect the primacy of the State's role in the program, and the Federal role only in the context of what the States have left undone.

Health Information Designs, Inc. Study of Issues Concerning CHAP Implementation - Administrative Progress Report 3: Summary Report -- Research of National Data, Washington, D.C., 1979.

In its study of the issues surrounding CHAP/EPSDT implementation, Health Information Designs, Inc., (HID) expands its information base to include research and analysis of pertinent national data. Increased emphasis on the identification and examination of specific issues facilitates 1) a more thorough understanding of the proposed Child Health Assessment Program (CHAP) and ongoing EPSDT program, 2) development of a more comprehensive data base for use by the Health Care Financing Administration (HCFA), and 3) critical examination of the four subject areas which are of central interest to this study. These four subject areas are "Screening in Public Schools," "Case Management Systems," "Community Based Organizations," and "Development of the State Implementation Plan Strategy."

Applied Management Sciences. Assessment of EPSDT Practices and Costs - Executive Summary of the Final Report, Silver Spring, MD 20910, 1978.

The primary objective of this analysis is to assess the impact of the EPSDT program on State Medicaid budgets. Earlier parts of the larger study, of which this analysis is a part, provided for the collection and analysis of Medicaid claims data from two States for the year that EPSDT screening took place (1975). Subsequently, an initial step in this analysis is undertaken to determine if the EPSDT program causes changes in the cost and utilization of Medicaid medical services between the pre-screening year (1974) and the year of the screening (1975). The Final Report completing this analysis presents data from the year following screening (1976) in conjunction with those from the two preceding years in a time-series analysis of the impacts of EPSDT on Medicaid utilization and program costs. The findings of the study suggest that further research is warranted on the relationship between the EPSDT process and consumer health care practices.

Applied Management Sciences. Assessment of EPSDT Practices and Costs - Final Report, Silver Spring, MD 20910, 1978.

The purpose of this study is to determine if the EPSDT program changes the cost and utilization of Medicaid medical services over time. To control for extraneous and unwanted sources of systematic variance in the study, and thus achieve the objective of clearly identifying the EPSDT impact on the utilization (and costs) of medical care, a non-equivalent control group design is used. The experimental and control groups were chosen from two pre-existing groups -- those who were screened and those who were not screened by



the EPSDT program between March, 1975 and February, 1976. The design controls for the main effects of history, maturation and testing procedures. The differences in the period before and after the screening are measured as percentage changes in utilization and cost. The age breakdown used is birth to six years, and seven to twenty-one years. Race is broken down into white and non-white (other), and two locations are chosen; one a more urban, more industrial northeastern State and the other a more rural, less industrial southern State. Whether EPSDT serves to change the actual health care habits of screened persons over time could not be definitely concluded from this study. However, the EPSDT process in the two States apparently results in two distinct effects: first, to significantly increase utilization concurrent with the receipt of screening services on a one-time basis; and, second, to raise the overall utilization of medical care among the screened sample to levels greater than those before screening and approaching those of the unscreened sample in the immediate short-run, i.e., one year after screening. Findings suggested further examination of the relationship between the EPSDT process and consumer health care practices.

Community Health Foundation. A Study of Broken Appointments in the Pennsylvania EPSDT Program, Evanston, IL, 1976.

Broken appointments are regarded as serious deterrents to the effective and efficient delivery of health care. High rates of broken appointments may contribute to low provider interest and reluctance in participating in the EPSDT program. The objectives of this study are 1) to identify probable causes for appointments being both kept and broken; 2) to identify strategies for reducing no-show rates; and 3) to identify ways of minimizing the impact of residual no-shows. In selecting counties to be included in the study, preference was given to counties with large numbers of eligibles and/or relatively high no-show rates. Interviews were conducted with county welfare directors, county Board of Assistance outreach workers and supervisors, clerical personnel, physicians, nurses, receptionists and contractor personnel. Site and home visits and followup phone interviews were useful in yielding data for the study. Some of the findings reveal that EPSDT programs usually can be expected to have higher broken appointment rates than well child programs which have more heterogeneous populations. Outreach is viewed as another significant factor which contributes to the higher no-show rate. This supports the position that families which initiate the request for service are more likely to keep the appointment. Other factors which influence the appointment rate are cultural and service variables.

Meier, J. Screening and Assessment of Young Children at Developmental Risk, 1972.

The purpose of this state-of-the-art monograph is to establish a common and substantive basis of discussion for participants in a national conference sponsored by the President's Committee on Mental Retardation (PCMR) to address the feasibility, design, and implementation of a massive screening and assessment system to detect infants and children at risk of being or becoming developmentally disabled while they are very young and presumably most amenable to treatment and habilitation. The paper is not restricted to early identification methods and materials pertaining to developmentally disabled children as defined by the Developmental Disabilities Act. Its

format breaks the screening procedures into four major categories, namely those dealing with physical factors, intellectual-cognitive factors, language factors, and socioeconomic factors. After these highly specific areas are dealt with, several existing and planned comprehensive screening and assessment systems are described. The monograph closes with several state-of-the-art observations.

Trans Century Corporation. Final Report - Preventive Care for Mothers, Infants, Children and Youth: A Literature Search and Recommendations for Further Research, Washington, D.C. 20009, 1975.

The objective of this study is to provide information to mark the way for policy research into the probable impact of National Health Insurance coverage on preventive care. Most important for policy considerations is the impact of such coverage on utilization rates. To answer many of the questions arising from such an impact, the contractor undertakes several tasks: 1) a comprehensive search of scholarly literature on preventive care, 2) identification and summarization of literature on effectiveness of preventive care, its costs versus its benefits, and utilization rates, and 3) summarization and differentiation of findings. For the majority of studies of preventive care programs, the literature search reveals the following defects:

1. Few studies produce economic estimates of benefits and costs of alternative intervention strategies;
2. Methodologies differ radically from one study to another, resulting in considerable difficulties in comparing the cost-benefit of alternative preventive measures.
3. The source of this lack of research findings resides in: a) not producing the valid and complete data baseline required for analysis by many existing preventive health care programs; b) under utilization of data sources; c) no evaluation methodology which could be uniformly applied for the economic analysis of preventive health care programs.

Bokonon Systems, Inc. EPSDT Policy Options, Washington, D.C. 20036, 1975.

In an effort to establish an appropriate focus for the development of an evaluation model for EPSDT, this paper attempts to relate the problems of efficient operations to program policy attainment. Based on reviews of legislative history and past efforts in delivery of pediatric health care, a series of potential policy options are identified and discussed in terms of their implications for evaluation. Also, concurrent with this effort, a review of present responsibilities in terms of monitoring and efficiency evaluation are presented.

Bokonon Systems, Inc. EPSDT State and Local Planning Issues - A Conference Report, Washington, D.C. 20036, 1975.



Recognizing the wide variation in data systems which has accompanied State EPSDT implementation, Bokonon Systems recommends the development of an evaluation model which utilizes existing State and local information. This approach is based on the idea that information utilized in State and local planning efforts can be classified according to EPSDT service requirements and the information obtained used to meet Federal evaluation needs. Conference participants reflect the range of personnel concerned with implementing EPSDT. During the course of the conference, many issues are raised which have to do with the basic philosophy underlying EPSDT as well as the problems of program implementation and maintenance. The report is divided into two sections. The first section details the concerns evidenced by participants during the conference. The second provides a final set of planning and evaluation issue questions which participants concurred upon.

Weber, James M. The Medicaid EPSDT Dental Program In Texas: Evaluation of the Public Health Impact, The University of Texas Health Science Center at Houston, School of Public Health, 1975.

One of the primary objectives of this evaluation is to establish base line data for comparison with future program evaluations within the State of Texas. Somewhat parallel to the development of the data base, the second objective is to determine the appropriateness of the conceptual model for evaluation of the EPSDT program which was developed by the Regional Research Institute at the University of Texas Health Science Center in San Antonio under a grant from the Health Services Research Institute (HSRI). One of the more difficult objectives of this study is to compare the level of care provided to clients of the EPSDT dental program with the needs of this population. The final objective of this report is to assess the public health impact of the EPSDT Dental Program. Public health impact is defined as the sum total and accumulation of all information pertaining to either the improvement of the dental status of the target population or other indirect measures which may signify an improvement in the patient's overall health. General findings reveal that from the inception of the dental EPSDT program in February 1973 until June 15, 1974, a total of 84,423 Texas recipients received some form of dental care, yielding a utilization rate of approximately 30 percent for this State annually. This rate of utilization is significantly higher than that reported by other similar programs.

Bokonon Systems, Inc. Literature Analysis - Evaluation of Delivery of Preventive Pediatric Health Services and Case Management Systems, Washington, D.C. (undated).

The purpose of this analysis is to examine efforts at evaluating programs similar to EPSDT, to identify potential methodologies and to eliminate ones which have already demonstrated their inability to provide results. To facilitate the analysis, the contractor structures EPSDT into a hypothetical model. An attempt is made to assess the literature in terms of the information which it provides vis-a-vis the subcomponents or elements of the model. The literature analysis is carried out in two areas: 1) a review of the methodology used in evaluating health care delivery systems, and 2) a review of evaluations of case management systems.

Community Health Foundation. State of Kentucky End-of-Year Report,  
Evanston, IL, 1977.

Community Health Foundation (CHF) prepared this year end report in fulfillment of its obligation under a contract awarded by DHEW. CHF conducted a needs assessment in Kentucky in November, 1976 and found a series of inter-related problems with the EPSDT program: 1) low screening penetration rate (20%); 2) high incidence of broken screening appointments (50-60%); 3) wasted efforts by Bureau for Social Services caseworkers; 4) inadequate resources (health and transportation) in rural areas; 5) low screening reimbursement; and 6) inappropriate screening periodicity schedule. As a result of the needs assessment, Kentucky's Department for Human Resources (DHR) and CHF agreed to two technical assistance areas: a) assisting DHR in developing an EPSDT outreach and case management proposal eligible for 75 percent Federal financial participation, and b) assisting DHR in evaluating the appropriateness of the State's screening periodicity schedule by providing a review of periodicity schedules recommended by professional groups.

Community Health Foundations. State of North Dakota End-of-Year Report,  
Evanston, IL, 1977.

This report is in fulfillment of a contractual effort by the Community Health Foundation (CHF) to assist North Dakota in implementing a successful EPSDT program. The program was implemented Statewide in June, 1976 after an 18 month experience with a prototype delivery model conducted in Minot. The major problem was increased cost per screening. This cost increase was attributed to the reduced number of eligibles requesting EPSDT services, the purported result of inadequate procedures for informing and outreach. To resolve the high screening cost issue, CHF suggested that the State hire additional EPSDT workers to perform the functions of client motivation and outreach or to redefine the responsibilities of social service workers to include these duties. Because any changes in program procedures and resource allocations must be approved by the North Dakota legislature, CHF agreed to perform a cost analysis study to determine the impact of the EPSDT program over a period of one year. Additionally, CHF provided the State with written materials to prepare a screening manual and to improve procedures for informing, outreach and case management.

Community Health Foundation. Cost Impact Study of the North Dakota EPSDT Program, Evanston, IL, 1977.

The purpose of this cost impact study is to assess the impact of the EPSDT program on Medicaid expenditures. The primary objectives of the study are to 1) determine the impact of EPSDT on the utilization of medical services in the State, and 2) determine to what extent the program has modified total expenditures for Medicaid child health in one community over a short term (one year). The major findings and conclusions of the study suggest differences in the utilization of medical services between Medicaid recipients who participated in EPSDT and those who did not, and differences in expenditures for those who participated in the EPSDT program and those who did not. Some of those differences were that 1). screened persons used 21 to 39 percent fewer inpatient hospital services but considerably more physician and dental services; and total per capita expenditures, including screening costs, were 36 to 44 percent lower for screened versus unscreened persons.



Community Health Foundation. State of Minnesota End-of-Year Report,  
Evanston, IL, 1977.

This study is both an update and needs assessment of the State of Minnesota's EPSDT program. The information was obtained principally through interviews with the State's EPSDT coordinator. Although Minnesota is very progressive in implementing its EPSDT program, the Community Health Foundation (CHF) identifies and develops two major projects for its Department of Public Welfare: 1) a ten page newsletter directed to potential EPSDT providers to generate interest in participating in the EPSDT program; 2) a study design to be used for comparing the health status of medical assistance recipients and their behavior in utilizing medical care.

Community Health Foundation. Final Report - Technical Assistance for Case Management System Development for New Jersey and Virginia (Abridged), Evanston, IL, 1979.

The Community Health Foundation (CHF) provided technical assistance in the form of a needs assessment and plan of assistance to the State of Virginia from October 1978, to January 1979. The State accepted this work as completely meeting its need for assistance with the EPSDT program. CHF's technical assistance for New Jersey consisted of three major products: 1) needs assessment, 2) recommendations for reorganizing child health services in New Jersey, and 3) proposed case management conceptual design. This report identifies and explains the relationships among the components of a proposed EPSDT case management system. The conceptual design is intended to serve as the basis for system analysis and programming. The formulation of the design is based on State identified needs and believed to be an effective and efficient approach to satisfying both current and potential case management needs.

Health Services Research Institute, University of Texas Health Science Center, Contra Costa County, California EPSDT Demonstration 1973-1977: Summary and Recommendations of Final Report June 1979. San Antonio, TX, 1979.

This report summarizes the findings of an EPSDT demonstration project to explore and demonstrate methods of delivering EPSDT services to children of low income families. The project was designed to increase the number of children screened, reduce the number of undiagnosed and untreated medical and dental problems present in the population of children eligible for the project services, and to improve their immunization status. This was to be done through the establishment and operation of a data system to facilitate smooth entry and retrieval of clinical and followup data. Recommendations of the project include the following: 1) Increased participation in EPSDT in about 18% of program eligibles in an urban environment, to encourage home visiting by community health workers, coordination with youth organizations and Headstart efforts, and encouragement of screening in schools where more than 60% of the children are Medicaid eligible; 2) utilization of nurses experienced in working in clinics to improve the staffing possibilities for clinics; and 3) focusing on the problem of getting children with dental or social emotional needs to treatment.











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